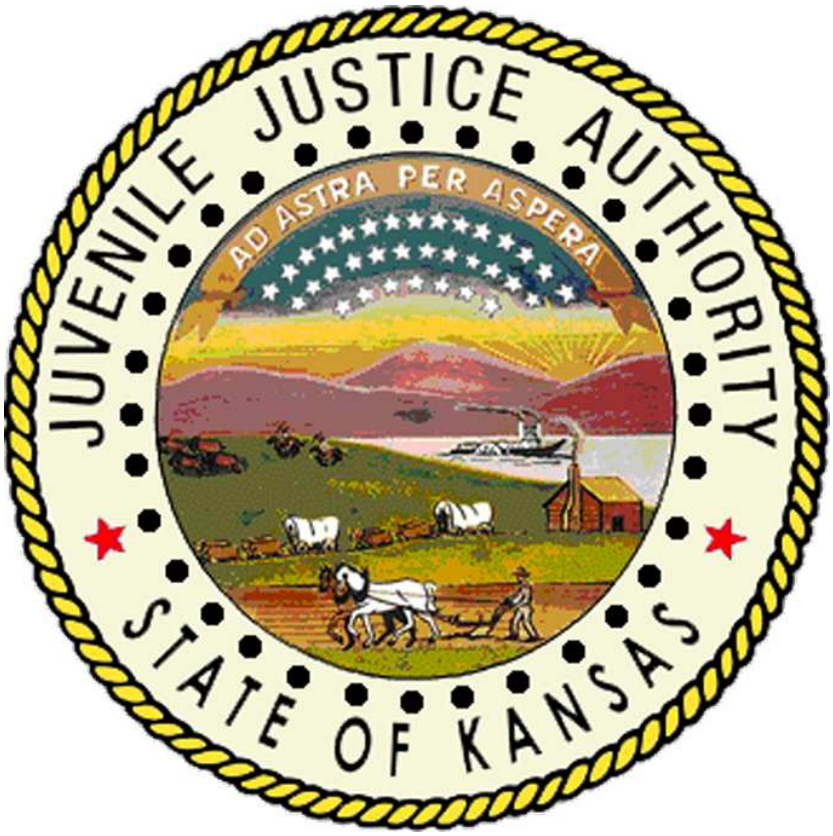
Provider



Handbook

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INTRODUCTION

The Juvenile Justice Authority (JJA) recognizes the importance of obtaining a full range of services for youth under the supervision or custody of the state of Kansas. The goals of intervention with youth, as spelled out in the Juvenile Justice Code and reflected in the agency mission:

The Juvenile Justice Authority assists youth to become successful and productive citizens by providing leadership and support to:

- Prevent youth from becoming involved in the juvenile justice system
- Provide community supervision for youth who are involved in the juvenile justice system
- Provide safe, secure, humane and restorative confinement of youth to enhance public safety
- Promote public safety by holding youth accountable for their behavior, and improve the ability of youth to live productively and responsibly in their communities.

Toward these ends, the Juvenile Justice Authority, working through Community Supervision Agencies, intends to contract for services which meet these goals. The Juvenile Justice Authority Provider Handbook sets the standards and the fees payable for those services.

In order to ensure the availability of services to meet the needs of youth under the supervision of the Community Supervision Agency, Community Supervision Officers are encouraged to identify the needs of the youth and incorporate those needs into the youth's individual supervision plan. The provider and Community Supervision Agency will then work in concert to insure that the appropriate services are accessed to meet the needs of the youth.

The Juvenile Justice Authority will hold a Provider Agreement with providers with whom the agency is interested in conducting business under the terms of the Provider Handbook. A list of those providers and the corresponding services they provide will be made available to each Community Supervision Agency. The Community Supervision Agency is authorized to purchase services for youth in the custody of the Juvenile Justice Authority under the conditions of the Provider Agreement.

The Community Supervision Agency will contract for services for an individual client, using the Client Service Agreement, and for out of home placements, using the Placement Agreement. Community Supervision Officers may contract only with providers holding a Provider Agreement with the Juvenile Justice Authority and may contract only for those services approved by the Juvenile Justice Authority.

The Provider Handbook additionally sets forth the General Requirements for all Providers, procedural information and JJA Policy Statements to which each Provider must adhere.

Part I: Information for all Providers

KANSAS JUVENILE JUSTICE AUTHORITY
GENERAL REQUIREMENTS FOR ALL PROVIDERS

For JJA to establish a Provider Agreement, all providers must continually meet all standards established in their respective provider manuals (see appropriate level of service below).

1. **Provider Qualifications:** Agencies who have not been able to hire individuals with either the academic qualifications or experience the standards required to do the job must submit a written request for exception to the Commissioner.

2. Each provider must notify JJA of any change in the program administrator and/or case coordinator. Upon a change in these program personnel, written verification that the new individual meets the requirements set forth in the Provider Handbook shall be submitted to JJA

3. **Provider Clearances:** All providers are responsible for providing documentation of clearance through the Kansas Bureau of Investigation and the Kansas Child Abuse and Neglect Registry.

4. **Confidentiality:** All providers are required to comply with applicable state and federal statutes/regulations regarding confidentiality of juvenile information.

5. **Reports of Child Abuse or Neglect:** All providers are required to report immediately to Social and Rehabilitative Services (SRS) any cases of suspected child abuse or neglect.

6. **Crimes Committed Against Youth:** JJA expects providers to train their staff to use common sense and community standards to determine whether a crime against a youth in their placement has been committed. It is the policy of JJA that all providers are required to have their staff report immediately to the local police department or county sheriff's office any case of a suspected crime or act committed by a juvenile which if committed by an adult would constitute a crime, committed against a youth who is in JJA custody and placed with that provider.

7. **Discipline and Behavior Control:** All residential providers and their personnel are required to adhere to the Juvenile Justice Authority policies governing discipline, physical restraint, and isolation. (Please reference the appropriate level of service standards that apply to your program and see the JJA Policy Statement regarding discipline.)

8. **Contracting with Individuals:** The Juvenile Justice Authority will only contract with individuals who are in business for themselves. The following issues shall be considered when determining whether providers are in business for themselves:

    - The provider is responsible for paying income and self-employment taxes as determined by the applicable state and federal rules. Normally they will have their own tax I.D. number and pay their own Social Security taxes.
    - The Juvenile Justice Authority provides no supervisory services to the contractor, nor is the Juvenile Justice Authority responsible for establishing confines of employment or working hours.
    - They provide all their own equipment, goods and tools to complete the necessary service.
    - All overhead costs (e.g., meals, clothing and transportation) are the responsibility of the provider, not the Juvenile Justice Authority.

- The provider is responsible for all of their own training and education.
- The provider is responsible for any liability involved in the delivery of services to consumers.
- Independent providers are free to accept business and referrals from the private sector.
- The Juvenile Justice Authority will report to the Internal Revenue Service a summary of earnings at the end of the year.

9. **Contracting with Relatives of Employees:** No JJA or Community Supervision Officer shall be involved in agency decision-making related to administrative contracts or provider agreements with a relative. In the event the Juvenile Justice Authority wishes to contract with a spouse, parent, child, sibling, in-law, or cousin of any employee, the Commissioner shall approve such contracts. The Juvenile Justice Authority shall exercise discretion when contracting with an employee's fiancé, roommate, partner or other individuals where the potential of financial gain to the employee exists.

10. **Contracting with the Juvenile Justice Authority:** Provider Agreements cannot be made to purchase services from the Juvenile Justice Authority or Community Supervision Agencies or their employees.

11. **Family Contact:** Subject to the provider's visitation guidelines (days of the week, times, appropriate attire, etc.), a provider shall not prohibit contact with a youth's immediate family unless any of the following:

    - A court orders no contact.
    - Documented violence, threatening or disruptive behavior by a family member that occurred during a contact.
    - Documented introduction of illegal drugs or weapons.

    Any denial of contact by a family member must be documented and reported immediately to the youth's Community Supervision Officer. Each provider should provide each youth and family with visitation guidelines upon admission. The youth's Community Supervision Officer is responsible to provide a contact list which should include the type of contact allowed (letter, phone, day passes, etc.).

12. **Personal Possessions:** All residential providers must preserve and relinquish upon termination of the placement, all personal possessions of the youth. These possessions must be preserved for thirty (30) days post termination of placement. Community Supervision Agencies are responsible for arranging for the return of the possessions. If such arrangements have not been made, providers may dispose of the possessions on the thirty-first (31st) day post termination of placement.

13. **Licensing:** All residential centers, group boarding homes, child-placing agencies and resource homes must be licensed as per the Kansas Department of Health and Environment (KDHE). All resource families must have completed a training curriculum for parents approved by KDHE. Please note, regardless of ages served, all residential providers (excluding TLPs and CIPs) will be required to obtain a KDHE license.

INDEPENDENT CONTRACTORS

1. You have the responsibility, as an independent contractor, to pay income and self-employment taxes as determined by the applicable state and federal rules. You should check with your accountant or the person who completes your income taxes to determine any responsibility.

2. The agency cannot specifically direct your hours as to when the service will be provided or how it will be provided. Any supervision of your services cannot come from the Juvenile Justice Authority or the Community Supervision Officer.

3. You are required to provide your own tools and equipment necessary to complete the service. Use of case management agency phones, mail, automobiles and office space is not allowed.

4. Compensation for services provided will be made as specified in the Provider Agreement and/or Client Service Agreement. Occasionally you will be requested to provide copies of these documents as proof that you are receiving these from the local agencies.

5. Overhead costs, (e.g., meals, clothing and transportation), are the responsibility of the contractor and not the Juvenile Justice Authority or the Community Supervision Officer.

6. You are responsible for your training.

7. You are responsible for liability involving the delivery of services to the Juvenile Justice Authority consumers. You are also responsible for all insurance coverage. It may be advisable to contact other independent contractors for information regarding liability risk.

8. You are free to accept referrals from other interested parties outside of the Juvenile Justice Authority.

9. You stand to realize a profit or suffer a loss as a result of the service being rendered.

10. You are responsible for your own quarterly income tax and social security. The Juvenile Justice Authority will report to the Internal Revenue Service a summary of your earnings at the end of each year.

Payment Procedures

1. **Rate Setting:** Rate setting will be done by the Juvenile Justice Authority and in certain circumstances will be done in conjunction with SRS. The maximum rate paid for a specific service will be the published rate in the Provider Handbook or will be the provider's usual customary charge, whichever is less. If the audited rate for specific services is less than the maximum rate established in the Provider Handbook, the Juvenile Justice Authority will purchase service at the audited rate.

2. **Negotiated Rates:** Rates listed in this handbook are considered to be maximum rates. Providers may not charge the Juvenile Justice Authority or the Community Supervision Agency more than their customary charges to the general public. The Community Supervision Agency may negotiate lower rates with individual providers for specific services.

3. **Face-to-Face Services:** Unless otherwise specified in the handbook, only actual face-to-face services are purchased. In other words, providers are not to bill the Juvenile Justice Authority for travel time, preparation time, report writing, etc.

4. **Medicaid Expectations:** Whenever possible, it is the expectation that Medicaid funds be used to purchase needed client services. For those clients who are not Medicaid eligible, or in those situations where the staff does not have access to Medicaid providers, then services may be purchased from other providers who meet the Juvenile Justice Authority qualifications and with whom a Provider Agreement has been developed. Individuals or agencies wishing to become enrolled Medicaid providers must contact the Kansas Health Policy Authority Medicaid Fiscal Agent, Topeka, Kansas, for a provider "enrollment packet."

Reimbursement for Absentee Days

See Psychiatric Residential Treatment Facility (PRTF) standards for rules governing reimbursement of Absentee Days in a PRTF. For non-Medicaid residential placements a youth shall be considered present at the placement for an entire day if the youth is at the placement at 11:59 pm. The placement should take a resident specific census at this time and ensure the placement has a record of which residents are present in the placement on any given day and can accurately track absentee days for each youth. Authorization for placement days shall be provided in accordance with the JJA Provider Handbook, excluding the day of discharge.

Providers will be reimbursed for absent days as detailed below. At no time shall a provider submit an invoice for days that differ from the criteria listed under each section.

- **AWOL Absentee Days:** If a youth is absent from placement due to being AWOL the placement will be reimbursed for the first twenty-four (24) hour period the youth is AWOL only if the youth returns to the placement within that twenty-four (24) hour period. If the youth does not return within the allowable twenty-four (24) hour time period, the youth's date of AWOL will be considered the day of discharge.

- **Hospital Leave:** This is an absence from the facility for more than twenty-four (24) consecutive hours due to the resident receiving acute inpatient treatment in a hospital, including treatment in a psychiatric unit of a hospital, or a state psychiatric hospital. If the placement is unable to plan for return of the resident and continue continuity of care planning because it i**s** unsure when the resident may return from the hospital the resident should be discharged. Under no circumstances shall the provider bill for more than five (5) days when the resident is in the hospital.

- **Visitation Days:** A maximum of (seven) 7 consecutive visitation days and up to ten (10) calendar days per month will be reimbursed at the contracted per diem rate. Note, the day the youth leaves for pass will count as day one (1) and the day the youth returns from pass will not count towards visitation days criteria. An approved visitation plan must be documented in the youth's program plan and the custodial case manager must approve the type, frequency, duration and location of all visits prior to the youth leaving for a visit.

- **Other Absentee Days:** If a youth is absent from the placement for a short time due to circumstances needing the youth's immediate attention (i.e. deaths, weddings, personal business, court appearances), the placement can be reimbursed for up to five (5) days per calendar month at the contracted per diem rate, unless the resident's placement is terminated sooner by the resident's custodial case manager in conjunction with the placement. If the youth is absent due to a court appearance, and during that proceeding the court takes action precluding the youth's return to the placement, the date of the court's action will be considered the day of discharge.

- **Absentee Days for Detention:** If a youth is absent from placement and placed in a juvenile detention center (JDC), this will be considered the day of discharge from the program. This would include a youth being placed in a JDC for sanction house by the Judge. Any youth discharged from your program to a JDC will have to be re-admitted to your program and will be considered a new admission.

GUIDELINES FOR PAYMENT OF DETENTION COSTS

In all situations, the Juvenile Justice Authority (JJA) will only pay for detention cost pursuant to Kansas law. A copy of the journal entry and any other relevant court documents must accompany all detention invoices that are sent to the Juvenile Justice Authority.

JJA PAYS FOR DETENTION COST:

1. In cases where the court orders a juvenile into JJA custody or temporary custody at the time of a detention hearing and recommends that JJA find an appropriate placement, JJA pays the detention cost from the date of the order forward until placement is achieved. In this case the court has given JJA custody and the authority to move and place.

2. In cases where a juvenile is in JJA legal custody on one case, but the juvenile commits a new crime and is arrested by law enforcement and is placed in detention, JJA pays for detention costs for the first 48 or 72 hour period prior to the detention hearing. If the *Court subsequently orders or recommends detention* at the detention hearing, the County pays the remaining cost for days in detention.

3. In cases where a juvenile is in JJA legal custody on one case, but the juvenile commits a new crime and is arrested by law enforcement and is placed in detention, JJA pays for detention costs for the first 48 or 72 hour period prior to the detention hearing. If the *Court subsequently does not order detention at the detention hearing, but places the juvenile back in JJA custody for appropriate placement on the old or new case,* JJA shall also pay the remaining cost for days in detention for the juvenile.

4. In cases where a juvenile is in JJA legal custody on one case, but the juvenile commits a new crime and is arrested by law enforcement and is placed in detention, JJA pays for detention costs for the first 48 or 72 hour period prior to the detention hearing. If the Court *subsequently orders or recommends detention at the detention hearing and places the juvenile in JJA legal custody* the County pays the remaining cost for days in detention.

5. In cases where the court orders JJA custody or temporary custody at the time of the adjudication hearing or sentencing hearing and recommends JJA find an appropriate placement, JJA pays the detention cost from the date of the order forward until placement is achieved.

JJA DOES NOT PAY FOR DETENTION COST:

1. In cases where the juvenile is not in JJA's legal custody on any case and is arrested by a law enforcement officer and ordered detained at the detention hearing, adjudication hearing, or sentencing hearing, the County pays detention costs.

2. In cases where the juvenile has been directly committed to a juvenile correctional facility at the time of adjudication or sentencing, JJA does not pay the cost of detention from the date of the order forward until placement at the juvenile correctional facility.

3. In cases where the juvenile is in JJA's legal custody and is brought back before the Court on a probation revocation or conditional release violation, JJA will pay the cost for the first 48 to 72 hour period prior to the detention hearing. If the Court subsequently orders detention at the detention hearing or revokes the conditional release and recommits the juvenile back to the juvenile correctional facility, the County pays the remaining days for detention until the Sheriff transports back to the correctional facility.

4. In cases where the court orders a juvenile into JJA legal custody or temporary custody at the time of the detention hearing and orders detention and orders JJA to find an appropriate placement, the County pays the detention cost until the minor is placed. In this case the court has made a specific placement to detention and JJA has no authority to move and place.

Special Note: Keep in mind that the examples will account for most but not every type of order that you will receive on the case. Always review the court's order for the intent of the Judge. If you are unsure, then ask the court for a clarification. If the Community Supervision Officer is in doubt as to the legal status of a particular case, then he or she should submit the journal entry along with the invoice so that a determination can be made by JJA.

Juvenile Justice Authority Discipline Policy

POLICY STATEMENT

I. DISCIPLINE

Discipline is an essential part of child rearing and when used positively it contributes to the healthy growth and development of a child and establishes positive patterns of behavior in preparation for adulthood. The Juvenile Justice Authority requires positive discipline for youth which the Juvenile Justice Authority purchases and/or provides services and care.

Positive discipline, when used for purposes of guiding and teaching the youth, provides encouragement, a sense of satisfaction, and helps the youth understand the consequences of their behavior. The Juvenile Justice Authority does not view as positive discipline any action administered in a fashion that may cause any youth to suffer physical or emotional damage. Disciplinary acts that cause pain, such as hitting, beating, shaking, cursing, or derogatory comments about the youth or the family are not acceptable.

IT SHALL BE THE POLICY OF THE JUVENILE JUSTICE AUTHORITY THAT WE NOT PURCHASE OR CONTINUE TO PURCHASE SERVICES FROM THIRD PARTY PROVIDERS WHO USE DISCIPLINE WHICH IS NOT POSITIVE, NOR WILL SUCH DISCIPLINARY ACTS BE TOLERATED WHEN PRACTICED BY JUVENILE JUSTICE AUTHORITY EMPLOYEES IN REGARD TO YOUTH IN ITS CUSTODY.

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Part II: Services

LISTING OF SERVICES

Below are the services available to the Juvenile Justice population.

Service Type	Pay Rates	Billable Unit	Page Numbers
Outpatient Sex Offender Treatment (ages 18-23)	$40.00	Session	13
Sex Offender Evaluation	$450.00	Evaluation	14
Family Foster Home	$19.82	Day	15
Emergency Family Foster Home	$36.66	Day	15
Maternity Foster Home	$49.64	Day	15
Specialized Family Foster Home	$49.64	Day	15
Relative Foster Home	N/A	N/A	15
Kinship/Non-related Kin Care	N/A	N/A	15
Therapeutic Family Foster Home	$115.00	Day	23
Juvenile Justice Foster Care	$99.00	Day	36
Youth Residential Center I	$59.93	Day	53
Youth Residential Center II	$126.00	Day	63
Emergency Shelters	$115.00	Day	74
Residential Maternity Care	$60.57 $10.02 baby	Day	85
Transitional Living Programs	$100.00	Day	96
Community Integration Programs	$95.00	Day	108
Detention	$120.00	Day	120
Psychiatric Residential Treatment	Variable	Day	124

NOTE: These rates are subject to change. Please see page 2 of the JJA Provider Agreement, Section II, Compensation.

Section 1: Treatment Services

1.1 OUTPATIENT SEX OFFENDER TREATMENT

(Ages 18-23)

Definition

Group Sex Offender treatment for those ages 18 through 23 who have been identified as appropriate for adult treatment by a psychosexual assessment.

Documentation

- Date service delivered, amount of time (number of billable units) and who delivered the service
- Monthly written case summaries
- Reports required by the court
- Discharge report

Minimum Qualifications

- Master's level in the Human Services field and licensed by the State of Kansas BSRB
- Minimum of two years of documented experience providing sex offender treatment services
- Follow Standards and Methods of the Association for the Treatment of Sexual Abusers (ATSA)

Duties

- Provide treatment within the time frames designated in the Client Service Agreement.
- Develop a treatment plan, identifying the goals of treatment.
- Document the major issues covered, changes in medication (if any, diagnosis, condition, and course of treatment).
- Report to outside agencies any suspected child abuse or neglect.
- Report any responsivity factors that require action by the referring agency.
- Attend supervision planning conferences, or provide a written report.
- Testify in court hearings as needed or required.
- At discharge, document the results of the treatment, suggestions for case action and recommendations, and the need for case action or intervention.

Section 2: Assessment Services

2.1 SEX OFFENDER EVALUATION

Definition

The administration and interpretation of various tests used to assess and evaluate an individual's risk of subsequent sexual recidivism, placement recommendations, treatment considerations and restrictions.

Documentation

Complete a contact log for each client that shall include:

- Description of the service provided.
- Date and time service provided.
- Total time spent providing the service.

The final written assessment reports serves as primary documentation.

Minimum Qualifications

- Master's level in the Human Services field and licensed by the State of Kansas BSRB
- Minimum of two years of documented experience providing sex offender treatment services
- Follow Standards and Methods of the Association for the Treatment of Sexual Abusers (ATSA)

Duties

- Administer assessment tools as needed.
- Interpret completed assessments.
- Identify presenting problem and reason for referral.
- Describe individual functioning at the time of the testing.
- Define the need for initiating/continuing intervention and/or treatment.
- Provide a written report of the findings, observations, recommendations and impressions.
- Psychological interview.

Segments to be included in the final written assessment are:

- Summary of Clinical Assessments
- Clinical Impressions
- Summary of Assessment
- Placement Considerations
- Recommendations

Section 3: Out-of-Home Placement Services

Family Foster Home Descriptions

Family Foster Home

A foster home is a family home in which 24-hour care is provided to children who are in need of out of home placement to meet their safety and well-being needs. The home must comply with KDHE licensure requirements, and be sponsored by a licensed child placing agency. The foster family is an integral part of the team working with the child and birth family to achieve timely permanency for the child.

Emergency Family Foster Home

An emergency family foster home is a family home in which 24-hour care is provided on an emergency basis to children who are in need of out of home placement to meet their safety and well-being needs. The home must comply with KDHE licensure requirements, and be sponsored by a licensed child placing agency.

Maternity Foster Home

A maternity foster home is a home in which 24-hour care is provided to a pregnant or postpartum youth and her child who is not a TANF recipient, who are in need of out of home placement to meet their safety and well-being needs. These homes must comply with KDHE licensure requirements, and be sponsored by a licensed child placing agency.

Specialized Family Foster Home

Each specialized family foster parent is required to comply with KDHE licensure requirements and the requirements of the sponsoring agency in regard to minimum number of in-service training hours to be obtained yearly. Specialized family foster parents are required to complete more annual in-service training than family foster parents due to specialized needs of the children/youth for whom they are providing care. Documentation of completion of in-service training hours must be kept in the specialized family foster parent's file. The purpose of in-service training is to provide opportunities for the specialized family foster parent to increase their skills and parenting ability particularly with respect to the differences they may encounter in raising children with the developmental needs of the child to be placed and not born to them.

Relative Foster Home

Twenty-four hour care in the home of a person related to the child. A KBI and SRS Child Abuse/Neglect Central Registry Check has been completed on all members of the family age 10 and over, and the child's referring agency has completed an assessment of the home to determine the child's safety and well-being needs will be met by placement in the relative's home. If KDHE licensing standards are met, relatives may receive financial assistance for the related child from the child's case management provider.

Kinship/Non-Related Kin Care

Twenty-four hour care in a family home setting for not more than 30 days, on a one time basis, for a specific youth with whom the kinship care provider has an existing supportive relationship with the youth or the youth's parent

Informal Care/Kinship Care should be the first choice for placement when the youth's family cannot provide adequate care. If the kin are not related to the youth, they shall be required to meet KDHE child

care licensing standards and regulations in order to provide out of home services. To expedite placement of youth with non-related kin, the requirement for the completion of PS-MAPP (the group process or Deciding Together) and the other training required prior to a youth being placed in the home is waived. The non-related kin shall be required to complete the PS-MAPP curriculum and other pre-service training prior to licensure.

Prior to the youth's placement, the Provider shall request from the local SRS Service Center a Child Abuse/Neglect Central Registry check on all members of the non-related kin family who are age 10 and over. The Provider shall also require the members of the family who are age 10 and over sign a statement, Declaration of No Prohibitive Offenses for KDHE Licensure, indicating a check of the KBI criminal history database will not reveal any conviction for offenses, unless they have been expunged, which would prohibit KDHE licensure. KDHE shall complete the KBI criminal records check prior to issuing the temporary permit.

Immediately following placement, the Provider shall complete the family assessment and licensing packet. The packet shall be sent to KDHE no later than 2 weeks after the youth's placement. KDHE shall review the packet and, if all requirements are met, issue a temporary permit by 30 days after the youth's placement. The temporary permit remains in effect for 90 days from the date of issuance. This temporary license may be extended for one additional period not to exceed 90 days, to allow the kin time to complete PS-MAPP. No further extensions shall be granted. Non-related kin shall comply with all licensing requirements of KDHE prior to a full foster home license being issued.

Case Management Providers shall negotiate a daily payment with the non-related kin providers to cover the cost of the youth's room and board. They shall also provide the same level of supports and services which are provided to other resource families to ensure the youth's needs are met and the placement remains stable.

Each child, newborn thru age 22, entering Kinship/Non-related Kin care shall have met criteria for this level of placement through use of a placement assessment tool utilized by SRS, the Child Welfare Community Based Service Provider, or JJA Community Case Management staff. Each youth being placed in Kinship/Non-related Kin care shall have an existing, supportive relationship with the Kinship/Non-related Kin care giver prior to placement. The relationship can be with the youth or the parent.

General Program Requirements and Guidelines for all Family Foster Homes

Section 1: General Program Requirements

- Twenty-four hour care in a family home meeting KDHE licensure requirements and sponsored by a licensed Child Placing Agency.
- Each family foster parent shall complete the PS-MAPP curriculum as a pre-service requirement
- Each family foster parent must be at least 21 years of age at the time of application to KDHE for licensure, and have been a member of the household for at least one year prior to application.
- Each family foster parent shall provide evidence of child care experience and knowledge of child care methods which will enable any child to develop his or her potential.
- The family foster home shall be licensed for a maximum of 4 foster children, not more than 2 of whom shall be under 18 months of age, with a total of 6 children in the home including the foster parents' own children under 16 years of age. Approval may be granted to care for 2 additional foster children in order to meet the needs of sibling groups or other special needs of foster children.
- The family foster home shall meet the legal requirements of the community as to zoning, fire protection, water supply and sewage disposal.

Section 2: Services Provided in a Family Foster Home

Services provided in a family foster home include: supervision, food, shelter, age appropriate daily living skills instruction, transportation, recreation, supporting parent/youth interactions (when these have not been prohibited by the court), participation in development, and review of case plan tasks and objectives.

The daily schedule shall address the needs of the youth and the use of time to enhance the youth's physical, mental, emotional, and social development. Indoor and outdoor recreation shall be provided. All play equipment, books, and other materials shall be safe, clean, in good repair, and suitable to the developmental needs and interests of the youth. The youth shall attend school regularly and also have time for school and community activities. The youth shall be provided opportunities to practice age appropriate daily living skills.

Section 3: Criteria for Admission

- Each child, newborn thru age 22, entering a Family Foster Home shall have met criteria for this level of placement through use of a placement assessment tool utilized by SRS, the Child Welfare Community Case Management Provider, or JJA Community Supervision Officer.
- A placement agreement must be completed between the family foster parents or the home's sponsoring agency and the youth's referring agency. A copy of the placement agreement must be kept in the youth's file in the family foster home.

Section 4: Accessing Outpatient Mental Health/Substance Abuse Services for a youth residing in a Family Foster Home

1. Child Welfare or JJA Community Case Management Provider's shall be responsible to complete a mental health and substance abuse screen for youth in the child welfare or juvenile justice system to determine each youth's need for further assessment in these areas.
2. If the mental health assessment indicates the need for outpatient mental health treatment services, the youth shall receive the appropriate mental health services through an associate of the Pre-Paid Ambulatory Health Plan (PAHP). The PAHP will periodically assess the youth's progress and continued need for outpatient mental health treatment.
3. If the substance abuse assessment indicates the need for outpatient substance abuse treatment services, the youth shall receive the appropriate substance abuse services through an associate of

the Pre-Paid Inpatient Health Plan (PIHP). The PIHP will periodically assess the youth's progress and continued need for outpatient substance abuse treatment.

4. If the Mental Health assessment determines the youth may be in need of inpatient mental health or substance abuse treatment, the youth must receive a Psychiatric Residential Treatment Facility screen or, if the youth's sole diagnosis is substance abuse, a referral shall be made to the PIHP.

Section 5: Scope of Services

- **Supervision: S**upervision will be provided by the foster parent or another appropriate caregiver during the foster parent's absence.

- **Food and Shelter:** Nutritious meals and snacks will be provided, the home will meet the child's health and safety needs, and each child has their own bed in a bedroom which meets KDHE licensure requirements.

- **Daily Living Skills Instruction:** Age appropriate daily living skills instruction will be provided in such skill areas as: personal hygiene, laundry, meal preparation, shopping, cleaning, money management, and health.

- **Transportation:** Transportation will be provided to school and medical appointments. The foster family may also assist in transporting the child to social events, interactions with parents, court hearings and reviews, etc.

- **Recreation:** Sufficient time for recreation and for individual, school, and community activities shall be provided.

- **Supporting parent/child interactions:** Foster parents will assure each child is available for the scheduled parent/child interactions directed in the child's case plan. Foster parents may choose to make their home available for some of these interactions or accompany the child to the site for the interactions to provide mentoring support to the birth family.

- **Participation in development and review of case plan tasks and objectives:** Family Foster parents are an integral part of the child's case planning team and are to be invited to participate in the development and review of the plan.

Section 6: Education

Family foster parents are responsible to insure school age youth attend school regularly, unless for an excused absence, and the youth complete homework assignments. If the youth will not be able to attend school due to illness or an appointment, the family foster parent is responsible to notify the school of this absence. The family foster parent will also communicate with the school in regard to the student's school progress and developing plans to address issues related to school performance.

Section 7: Child's Rights

Each child residing in a foster family home shall have an opportunity for:

- privacy
- contact with their case manager without the family foster parent present
- recognition of the child's cultural and religious heritage
- taking personal items with them when they leave the foster home

Section 7.1: Forms of discipline not allowed in the family Foster home include:

- physical discipline, including hitting with the hand or any object
- restricting movement by tying or binding
- confining in a closet, box, or locked area
- withholding food, rest, or toilet use
- refusing access to the family foster home

Section 8: Record Keeping Requirements for the Family Foster Home

Section 8.1: Youth's File

The family foster home shall maintain a file for each youth in placement. The file shall contain the following information:

- Youth's name and date of birth
- Name and address of the youth's referring agency case manager/social worker
- Placement Agreement or Client Service Agreement (for youth placed by SRS staff)
- Medical and surgical consents
- Medical and dental records
- Record of youth's prescription and non-prescription medications and when administered
- Authorization for release of confidential information
- Log of critical incident reports

Section 8.2: 30-Day Progress Reports

Thirty-day progress reports shall document youth's adjustment in the home, school performance (if school age), medical, dental, vision, and mental health appointments, critical incidents reported, interactions with parents, and any other significant events or issues related to the child and the placement.

Section 8.3: Transfer of Child's Medical Records

When a child leaves a family foster home to return home or moves to another out of home placement, the child's medical records shall be given to the child' referring agency to accompany the child.

Section 9: Family Foster Parent In-service Training

Each family foster parent is required to comply with KDHE licensure requirements and the requirements of the sponsoring agency in regard to minimum number of in-service training hours to be obtained yearly. Documentation of completion of the in-service training hours must be kept in the family foster parent's file. The purpose of in-service training is to provide opportunities for the family foster parent to increase their skills and parenting ability particularly with respect to the differences they may encounter in raising children not born to them.

Training should be related to one of the following topic areas:

- Developmental needs of the child to be placed
- Roles and relationships between the agency, foster parent, birth parent, and child
- Child management and discipline techniques
- Separation and the importance of the child's family
- Importance of the child's continued communication and contact with family
- Supportive services available to the child and to the foster family from the community
- Communication skills
- Constructive problem solving

- First aid, blood borne pathogens, CPR, medications
- Home safety
- Human sexuality, including the needs and behaviors of children who have been sexually or physically abused

Section 10: Abuse/Neglect Reporting

Physical Abuse means the infliction of physical harm on a child or the causation of a child's deterioration, or the likelihood of harm or deterioration. K.A.R. 30-46-10

Sexual Abuse means any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include allowing, permitting, or encouraging a child to engage in prostitution or to be photographed, filmed, or depicted in obscene or pornographic material. Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity, or coercion. K.A.R. 30-46-10

Mental or Emotional Abuse means the infliction of mental or emotional harm to a child or the causation of a child's deterioration. This term may include, but shall not be limited to, maltreatment or exploitation of a child to the extent the child's health is likely to be harmed.

This term may include the following:

1. terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;
2. emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child;
3. corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behaviors. K.A.R. 30-46-10

Neglect means any act or omission by a parent, guardian or person responsible for the care of a child resulting in harm to a child or presenting a likelihood of harm and the acts or omissions are not due solely to the lack of financial means of a child's parent or other custodian. Neglect may include but, shall not be limited to:

1. failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;
2. failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or the likelihood of harm to the child; or
3. failure to use resources available to treat a diagnosed medical condition if the treatment will make the child substantially more comfortable, reduce pain and suffering, correct or substantially diminish a crippling condition, or prevent the condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202(t)

As a mandated reporter, a family foster parent must report all witnessed or suspected abuse/neglect to the child/youth's referring case manager/social worker and SRS through the SRS Kansas Protection and Report Center (1-800-922-5330). Abuse is any act or failure to act which results in death, physical harm, emotional harm, or which presents a likelihood of harm to a person under age 18. The broad definition of abuse includes physical abuse, emotional abuse, and sexual abuse. Neglect is any act or omission resulting in harm to a child or which presents a likelihood of harm. Neglect includes failure to provide food, clothing, shelter, safety, adequate levels of appropriate supervision, medical treatment, or education.

Section 11: Critical Incident

A Critical Incident is an occurrence that requires the provider to make a response that is not a part of the program's ordinary daily routine.

Section 11.1: Critical Incident Reporting

Critical incidents are to be reported to the youth's custodial case manager and the youth's parent or guardian when appropriate.

Each foster care family shall obtain on-call/emergency contact information for all custodial case managers in the event of an emergency or critical incident.

The following critical incidents should be verbally reported immediately with a written report to the custodial case manager within 24 hours of the event (please refer to the following definitions for clarification):

- **Attempted suicide**: The attempt to intentionally kill oneself and the attempt caused injury or could have resulted in serious injury or death if not detected.
- **Suicide**: Intentionally killing oneself.
- **Homicide**: The killing of one person by another.
- **Other death**: Accidental death or death from natural causes of youth.
- **Assault/Battery**: Verbally creating fear of bodily harm and/or the causing bodily harm against another person.
- **Sexual misconduct**: Any sexual conduct between youth or between youth and staff/volunteers. Sexual conduct includes the intentional touching of another person's intimate parts, or the clothing covering the immediate area of the intimate parts, committed with sexual or aggressive intent.
- **Alleged maltreatment of youth**: Any act or situation of abuse and/or neglect, as defined by K.A.R. 30-46-10.
- **Serious youth injury/illness**: Any youth illness that requires the youth to be hospitalized or receive significant medical treatment. Significant medical treatment is treatment that could not be handled by a trained health care person outside of the hospital or clinical setting.
- **Serious infectious disease**: Diseases such as, but not limited to TB, Hepatitis A/B/C, or a serious sexually transmitted disease as tracked by the Center for Disease Control (CDC). This only needs to be reported if there is a threat of transmission of the disease to staff or other youth.
- **Riot/Hostage situation**: Any disturbance by three or more youth that seriously disturbs the operation of a facility, jeopardizes the control of an area, threatens violence against or destruction of property, or results in significant property damage or personal injury to youth or staff. Includes any hostage situation.
- **Natural disaster**: Acts of nature which cause personal injury to staff and/or youth or which causes structural damage to the physical structure housing youth.
- **AWOL**: A youth's departure from a placement or supervision without lawful authority, as defined by K.S.A. 75-712f. This also includes youth while on a supervised off grounds setting (i.e. transports, hospital, and medical visits). Reported verbally to law enforcement and the custodial case manager immediately with a written report to the custodial case manager within 24 hours of the event. An immediate verbal notification is to be made to law enforcement and to the custodial case manager when the youth returns or is located.
- **Other**: Any action or situation which would require a response by law enforcement, the fire department, an ambulance or another emergency response provider. Incidents in this category would also include any incident not reported in another category and have the potential for significant media coverage.

If the critical incident involves abuse or neglect, the facility must also follow mandated reporting requirements.

All facilities must have procedures for reporting critical incidents to administrative staff and recording critical incidents in the resident files. An administrative file of critical incidents must be kept by facility.

An administrative file shall be kept by the facility documenting critical incidents that is separate from the documentation in the youth's file.

THERAPEUTIC FAMILY FOSTER HOME

A Therapeutic Family Foster home is a family home in which 24-hour care is provided to children who are in need of out of home placement to meet their safety and well-being needs. The home must comply with KDHE licensure requirements, and be sponsored by a licensed child placing agency. The foster family is an integral part of the team working with the child and birth family in order to achieve timely permanency for the child.

Section 1: Therapeutic Family Foster Home

The over-all purpose is to improve the mental health status, emotional, and social adjustment of youth who require out of home therapeutic placement. Placement in Therapeutic Foster Care (TFC) occurs to support the youth, allow the youth to function in a setting outside of an inpatient hospital, or prevent the inpatient placement of the youth.

The Kansas TFC standards are predicated upon the National Program Standards of the Foster Family-Based Treatment Association (http://www.ffta.org). The national standards indicate that TFC "is agency led and team oriented". It is not simply the provision of higher payment and more training to foster parents for work with more difficult children or youth. Nor is it solely the addition of therapeutic resources external to the treatment foster home.

Section 1.1: Goals and Objectives

To facilitate youth reaching the optimal functioning and ability to reside in the community in the least restrictive environment, Long term goals of the service are:

- Improve emotional, mental, and functional status of individuals receiving services;
- Reduce unplanned placement changes;
- Increase the youth's ability to live safely, attend school, and be productive in an inclusive community environment;
- Increase the likelihood of a youth's successful return to the family or the successful implementation of permanency planning; and
- If developmentally appropriate, increase the youth's capacity for independent living.

Section 2: Description of Youth to Be Served

Youth placed in Therapeutic Foster Care must be in need of therapeutic intervention. Clinicians and others familiar with the youth must document that the youth is at serious risk of placement in a highly structured residential treatment program, but that the youth has enough internal control to be served in a structured family home environment by knowledgeable trained foster parents with the support of specialized behavioral management, school, and psychotherapy or behavioral therapy services.

These youths may exhibit well established patterns of behavior or conduct which are antisocial, oppositional, defiant, aggressive, abusive, impulsive, rebellious, self-defeating, or sometimes self-abusive. Youth with special medical needs or developmental disabilities may also require TFC if their behavior is such that specialized care is warranted. TFC eligible youth may also display a limited ability to delay gratification and show social and emotional immaturity. They may exhibit significant interpersonal relationship problems associated with such symptoms as withdrawal, aggressiveness, Asperger's or autistic patterns, or peculiar behaviors resulting in rejection by peers. They may have problems with substance use disorders, sexual acting out, running away, or destruction of property. Youth approved for Therapeutic Foster Care may also display poorly developed self-help or communication skills.

These youth's severe behavioral disturbances are primarily derived from environmental influences although some may exhibit patterns of mild to moderate mental illness. Various medical conditions may complicate the overall treatment picture. Affective disturbances will likely be prevalent as will be ADHD. Due to a history of severe physical, emotional, or sexual abuse, youth requiring TFC may avoid adult relationships, appear impersonal or detached, or exhibit serious oppositional tendencies. Sexual acting out associated with past sexual abuse will also likely be seen in the typical TFC setting. Youth appropriate for TFC referral are generally not an immediate danger to harm themselves. They may be potentially dangerous to others or property through their aggression and disregard for other's rights.

Youth in these circumstances require a high degree of supervision and intensive service. The youth may have received treatment in psychiatric institutions, higher levels of residential treatment, or they may be youth for which diversion from higher levels of treatment is recommended. They may be dually diagnosed youth who require a combination of support services and therapy to regain control of their physical actions.

TFC youth may exhibit severe interpersonal relationship difficulties, especially with peers. However, they should be able to demonstrate at least some positive response to adults and authority. Bizarre or peculiar behaviors may be exhibited which are sometimes only understood when the underlying causes and dynamics of the behaviors are understood. Hyperactivity and a hyper-responsiveness to external stimulation will likely be seen in various cases. Periodically, these youth may need external controls placed upon them. Many of these youth may be placed on psychotropic medication to facilitate control of impulses, emotions, attention capacities, or activity levels.

Youth who are immediately dangerous to themselves or others should not be referred to TFC. Conversely, youth who do not demonstrate a need for considerable supervision, support, psychotherapy, specialized school services, psychiatric services or an inability to function within their biological family environment, should be helped in a less treatment intensive arrangement.

NOTE: Therapeutic Foster Care services are limited to special needs children who are at eminent risk of placement in a psychiatric care, developmental disability care or residential facility or who are referred from such a facility.

Section 3: General Program Description

TFC providers must demonstrate the clinical and administrative capacity to provide quality services by meeting the criteria listed below. The Licensed Child Placing Agency or the therapeutic family foster parents do not provide acute inpatient, psychiatric, or substance use disorder residential treatment. Each therapeutic family foster home shall meet KDHE licensure requirements and shall be sponsored by a licensed child placing agency. The provider shall state whether the services under the Provider Agreement will be carried out by the provider's staff, by subcontracted staff, or through cooperative agreements. The provider shall provide, as part of the application, copies of such agreements.

The provider must agree that no more than two children will be cared for at any one time in each therapeutic foster home. Exceptions can be granted for the additional placement of siblings or stepsiblings of the TFC youth, provided that CFS/JJA, the referring agency, and TFC program staff all agree that it is clinically good practice to do so and document the rationale for that decision in the TFC Program youth's case file. Services are to be provided to a small number of youth at a time in each therapeutic family foster home to insure that the children will achieve success with the goals outlined in the Treatment Plan.

Each child's treatment plan shall be reviewed every 90 days by the child's treatment team. The treatment team is composed of the Social Worker Case Coordinator, Case Coordinator Supervisor, child/youth, (if age appropriate), biological or adoptive parents (when appropriate), therapeutic family foster parents, and the therapist who is an associate of the PAHP. CWCMP/SRS/JJA Case Managers, other Clinical

Consultants, and educators working with the youth in the local school district are also considered to be an integral part of the treatment team. The review shall be documented in the child's case file.

Providers will use the National Standards of the Foster Family-Based Treatment Association (FFTA) as a guide in addition to standards given in this document. The Provider must agree that prior to placement in Therapeutic Foster Care; the child will meet the criteria for placement, as determined by a score on the referring agency's placement screening tool and by meeting the general criteria for eligibility for placement in TFC.

Section 4: Scope of Core Services

The provider will operate and maintain a TFC program and conduct a program evaluation. Criteria for Therapeutic Foster Care are minimum requirements; exceeding the requirements does not automatically qualify providers for any other program designation. In addition, please refer to Section I of the National Standards for more clarification and discussion.

Daily Living Services - daily living services shall be provided and include the following:

- Room, board, child care, personal spending money, and school fees.
- Transportation to appointments within a 60-mile radius; including to and from school, medical care, recreation, etc.
- Academic activities - assistance with school work, vocational training, and/or G.E.D. training.

Situational Training- to include but not limited to:

- Personal Hygiene – teaching about body cleanliness, use of deodorants and cosmetics, appropriate clothing, choosing clothing to fit individual and occasion, and keeping clothes neat and clean.
- Health - Identifying and understanding residents' health needs; securing and utilizing necessary medical treatment including preventive and health maintenance services; gaining information and education in health maintenance (including preventive measures, nutrition, menstruation, rest, cleanliness, family planning, drugs, sexually transmitted diseases, exercise, and motivation for meeting own health needs), maintaining contact with providers of health services (physician, nurse, clinic) and using outside resources for assistance (clinics, pharmacies, hospitals). KAN BE Healthy screening must be provided according to the periodicity schedule and needed follow ups must be completed.
- Consumer education for independent living- Budgeting, comparative buying, installment buying, avoiding risks, identifying illegal or excessive interest rates, use of credit, avoiding or dealing with debts, using checking and savings accounts, and paying taxes.

Communication skills:

- The youth's articulating thoughts and feelings through appropriate use of such skills as speech, writing, and use of the telephone.

Home Management:

- Making the bed and changing linens, using the vacuum cleaner, dusting, organizing belongings, disposing of trash, cleaning all areas of the home, operating appliances, cooking complete meals, making simple repairs, who to call when a major repair is needed, being aware of the need for upkeep, handling emergencies, knowing first aid.

Situational Guidance:

- Identifying and accepting strengths, developing patterns of acceptance and coping with authority figures, getting along with others, sharing responsibility, being considerate of others, developing friendships, knowing when to go home when visiting, recognizing or modifying attitudes toward self or others, responsible work attitudes, tolerance of verbal criticism, reactions to praise, punctuality, and attendance.

Recreation:

- Participating in leisure time activities, learning how to spend leisure time, developing outside activities, managing time, finding recreation with little or no expense involved, finding community projects to take part in, participating in social groups, participating in sports and games, arts and crafts, and appreciating fine arts.

Behavioral Health:

- Crisis management, social rehabilitation and counseling, Behavioral programming (including design, consultation and supervision), Counseling towards reunification with family (if appropriate), supportive counseling including the identification of behavioral and substance use disorder support services needed for successful transition into the community. If developmentally appropriate, services which develop increased capacity for independent living.

Therapy:

- Individual and/or group therapy as well as psychosocial groups shall be provided as needed and indicated in the treatment plan for the individual youth. Therapy services are not part of the content of services for TFC, but rather are provided by associates of the PAHP. Therapeutic family Foster parents are expected to provide the basic day to day counseling the child needs in order to meet treatment goals. The case coordinator shall insure that individual or group therapy indicated by the treatment plan is implemented, reviewed as required, and modified as needed. The service delivered shall be documented in the individual's case record, including date, place, amount of time, and names of the therapist providing the service. The therapy shall be directed towards helping the youth adjust to life in the therapeutic family Foster home, making the experience a period of continuing physical, mental, emotional growth and assist the youth to understand and accept his family relationships, interpersonal relationships and personal situations. The ultimate goal is to assist the youth to prepare to function effectively outside the therapeutic foster home setting.

Tutoring:

- Tutoring for remedial purposes shall be provided as needed in addition to normal school work to assist youth to perform at his/her potential. Tutoring services should be in accordance with need as indicated by school staff. The service delivered shall be documented in the individual's case record including date, amount of time, and person who provided the service.

Case Coordination:

- Responsibility for coordinating the youth's program and progress with the schools, employer, family, referring agency, therapist, and other appropriate community Foster s for each youth in residence shall reside with Case Coordinator.

School/Work Liaison:

- The Licensed Child Placing Agency shall ensure routine communications between the staff and any educational program in which the youth is placed. This may include requesting and participating in the development of an Individual Education Plan for each resident. The necessity of the latter activity will be decided in conjunction with the worker assigned to each youth. The day to day school liaison activity may be the responsibility of the therapeutic foster home. These contacts shall be noted in the youth's case record.

NOTE: For youth in an employment program, similar contacts and services are to be provided in conjunction with the youth's employer when appropriate.

Section 5: Treatment Plan Design

The treatment program design includes a process for assuring appropriate services to a youth determined to be eligible for Therapeutic Foster Care services. The process includes:

- An initial screening by the case coordinator at the time of admission to the Therapeutic Foster Care Program (or prior to admission, if possible) to determine the needs of the youth.

- A master treatment plan to be developed within fourteen (14) days which includes input from the members of the treatment team and therapeutic family foster parents, as well as family involvement (unless contraindicated by legal constraints). Discharge planning should be included in the master treatment plan in order to set goals which reflect youth, parent, and other community stakeholder input. Long term goals in the areas of physical /emotional health, family relations, daily living skills, academic and/or vocational skills, interpersonal interactions, and community relationships shall be addressed, according to the age appropriateness of the plan in relationship to the youth being served. Goals of treatment plan shall be described, treatment techniques or programs used to treat must be identified, and time frames for reaching goals must be defined. Persons responsible for individual goals of the treatment plan must be identified and should sign the plan, thus indicating their agreement to provide the service or treatment. The resident should sign, if of sufficient cognitive ability to grasp the concept of the treatment plan. The Master treatment plan shall be reviewed, revised and documented in quarterly reports at least every 90 days by the TFC treatment team.

Section 5.1: Case Coordinator responsibilities

- The primary case coordinator will:
    - Develop the treatment plan in conjunction with the treatment team
    - Coordinate and implement the treatment plan;
    - Involve parents and family members in the treatment process, when appropriate;
    - Coordinate treatment with other involved agencies;
    - Provide training to therapeutic family Foster parents on the individualized treatment plan; and
    - Observe and document implementation of each youth's individualized treatment plan, including the in-home treatment aspects utilized by the therapeutic foster parents.
    - Be available to therapeutic family foster parents 24 hours per day for crisis consultation.
    - Minimally, face to face consultation with therapeutic family foster parents and the child must be provided one time per week during the first month of placement of a child. Thereafter, face to face consultation for therapeutic family foster parents and child must be provided two times per month until the child completes the therapeutic foster care program. These, however, are minimal guidelines, and are in no way meant to reflect that only this level of support is required if there are severe problems that must be addressed.

The level of case coordinator contact should be addressed in the Master Treatment Plan and should be based upon the problems that are to be treated. Weekly contact by phone must be maintained with both the therapeutic family foster parents and the child regardless of the situation.

Section 6: Program and treatment planning, documentation and review

The following shall be maintained in the case record for each youth.

Section 6.1: Initial Assessment

Prior to placement in a TFC program, a youth's strengths and needs shall be assessed. The assessment shall include but not be limited to the following:

1. Reasons for referral to the TFC program;
2. Evaluation or assessment in the areas of physical health/medication needs, family relations, academic or vocational training, community life, interpersonal interactions, daily living skills and treatment needs.
3. Establishment of a score on the placement screening tool. These assessment results will be made available to the TFC program, shall be discussed with the therapeutic family Foster parents prior to agreement to accept the placement and shall be made a part of the TFC child case record.

Section 6.2: Master Treatment Plan

Each youth residing in a therapeutic family foster home must have a written treatment plan based on a thorough assessment, within 14 days of placement. Treatment Plans must be signed by members of the treatment team and when possible the youth. The Treatment Team is composed of the Social Worker Case Coordinator, Case Coordinator Supervisor, child/youth, (if age appropriate), biological or adoptive parents (when appropriate), therapeutic family Foster parents, and the therapist who is an associate of the PAHP. CWCMP/SRS/JJA Case Managers, other Clinical Consultants, and educators working with the youth in the local school district are also considered to be an integral part of the treatment team. **(NOTE: If the family is not involved in the treatment process, the reason for this must be documented in the TFC file.)**

The name(s) of staff responsible for meeting the youth's needs shall be recorded on the treatment plan. The Plan shall include the following:

1. Long term goals in the areas of physical health, family relations, and daily living skills; academic and/or vocational skills, interpersonal interactions, and community living;
2. Short term goals which will help a youth eventually reach his/her long term goals in each of the above areas;
3. Specific plans for reaching the short term goals including services to be provided and frequency;
4. Estimated time for reaching short term goals.

The master treatment plan shall be reviewed and revised at least each 90 days. At that time a general written quarterly progress report should be completed by the TFC program and therapist. Information obtained from the parent, guardian, referring agency and the youth shall be considered in the report and updated treatment plan.

Section 6.3: Weekly Progress Notes

Therapeutic family foster parents and TFC program staff must provide weekly input and feedback to the development, revision, and evaluation of the treatment plan as well as carry out the in-home strategies.

Assessment documents must be included in the case record. Weekly progress notes, written by the case coordinator and therapeutic family foster parents, must be entered into the youth's chart, reflecting the delivery of services according to the treatment plan. This documentation must address the youth's responses to treatment interventions and progress of the youth on individualized goals and objectives. The note should include any significant events or critical incidents that occurred during the week and summarize contacts with family members and other involved agencies. If an unmet need is identified, the note must reflect actions to be taken to revise the plan for the youth.

Section 6.4: Permanency Planning

Assessment and treatment of the youth and family that focuses on opportunities for the youth to have ongoing active and meaningful connections to the family, kin, relatives, and community. The goal for achieving permanency shall be coordinated with the referring agency and included in the treatment plan. The permanency plan shall include strategies and tasks to accomplish the strategies. Behaviors which place the child at risk for disruption, activities to prepare the child's family or kinship network for reunification, and the identification of other less restrictive living environments and preparing the child for transition to these settings shall be addressed. The National Standards indicate that "family involvement requires an unwavering commitment to promoting a service that is culturally competent and respectfully embraces cultural diversity. TFC programs actively support and enhance children's relationships with their parents, siblings and other family members throughout the period of placement regardless of the permanency goal."

Section 6.5: Discharge Summary/After Care Plan

A discharge summary shall be completed at the time of the youth's discharge including delineation of aftercare plans and goals which the youth reached. While discharge planning should begin at the time of placement in therapeutic foster care a written plan is still necessary. Written recommendations for aftercare shall be made and should specify the nature, frequency, duration, and responsible parties for aftercare services.

Section 6.6: File Documentation

A dated record of significant observations and occurrences involving each youth shall be maintained. The record shall include events which may affect the wellbeing of the youth. The record shall be available for review. Each report shall include the date and time of occurrence, the staff member and/or youth involved, the nature of the incident and the circumstances surrounding it. The file shall also contain the Placement Agreement or Client Service Agreement (for child/youth referred by SRS staff).

Section 6.7: Health Records

Records of medications shall be kept in each youth's case medical record and include: the name of the prescribing physician; the name of the medication; the dosage prescribed; the purpose of the medication; noted side effects; the date of the prescription; and the date of review at least every three (3) months. A record of medication given, amount, date and time, and person dispensing shall be recorded. All doctor and dental visits, major illnesses and accidents shall be recorded. A current Kan-Be-Healthy must be maintained by the TFC program on each youth. Allergies of any resident youth should be displayed in a conspicuous place in the case file as well as in the medical section. The health record shall also contain a copy of the child/youth's current medical card and medical consent forms.

Section 6.8: Service Documentation

Documentation of services provided shall include: who received the service; staff person providing the service; amount of time spent providing the service; what service was provided; when was the service provided; and where was the service provided. Written critical incident reports are required to be sent to

SRS/JJA or the out of home placement contractor for SRS within 24 hours of the incident.

Section 6.9: Reports

Quarterly Reports shall document progress on specific short-term treatment goals, describe significant revisions in goals and strategies, and specify any new treatment goals and strategies during the period covered. The quarterly progress reports shall summarize progress and note changes regarding long-term placement and treatment goals. The report will be signed by the Supervisor and Case Coordinator at least every 90 days. Information obtained from the parent, guardian, the referring agency, Case Coordinator, Supervisor, therapist(s) and the youth shall be considered in the report.

Section 7: Home Visits

When home visits are a part of the treatment plan, there shall be pre and post home visit contacts between the youth, their family and the therapeutic family foster parents or the agency program staff regarding the home visit. Because the goal of placement is return of the youth to a family-like setting, it is important that home visits be carefully planned and executed in the best interests of permanency planning for the youth.

Section 8: Sponsoring Agency, Staff, and Therapeutic Family Foster Parent Qualifications

Section 8.1: Sponsoring Agency

The Sponsoring Agency must be a Child Placing Agency licensed by KDHE. There must be social work staff designated by the Child Placing Agency to provide services to therapeutic family foster homes. The TFC Program must meet the National Standards of Foster Family-Based Treatment Foster Care, in addition to the other standards listed in this document.

Section 8.2: Administrator

There shall be an administrator with a minimum of a Bachelor's Degree in Social Services or Human Services, and at least two (2) years' experience in administering a child welfare service delivery program or a related program commensurate with the size and complexity of the agency; a thorough understanding of philosophy, purpose, and policy of the agency; and the capacity to provide direction and leadership of the agency.

Section 8.3: Supervisor

Each TFC program will designate supervisors for their Case Coordinators. Preferably a Supervisor will have a Master's degree in social work and a license to practice in the state of Kansas with a minimum of two years' experience in the child placement field. However, a Master's degree in a related human service field can substitute for the advanced social work degree provided the Supervisor is licensed to practice in the state of Kansas and has three years of experience in the child placement field.

Section 8.4: Case Coordinator

Case Coordinators shall have a Master's degree in social work or in a related human service field and a license to practice in the state of Kansas. However, a Bachelor's degree with a license to practice in the state and at least two (2) years' experience in child placement/foster care is acceptable.

Section 8.5: Case Load Capacity

Supervisors shall supervise no more than 5 Case Coordinators. Case Coordinators shall be assigned no

more than 8 youth in TFC homes, although, in some circumstances, exceptions can be made for the case load to increase to 12. The case load should be adjusted downward if a difficult client population requires more intensive support and contact or if the travel/distances impair the Case Coordinators ability to serve the needs of the youth or foster parents. The Case Coordinator should supervise no more than 8 TFC homes.

Section 8.6: Therapeutic Family Foster Parents

- Must be licensed as foster parents by KDHE and be sponsored by a licensed child placing agency.
- Complete the PS Model Approach to Partnerships in Parenting (PS-MAPP) preparation program. This training shall be completed prior to placement of any child in the home.
- Shall receive, after the first year, a minimum of 24 hours, per parent in the home, of additional training annually. CPR and First Aid training does not count toward meeting the minimum 24 hours of annual training per parent in the home. This training shall, at a minimum, consist of: administration of medication; orientation to mandatory abuse/ neglect reporting; SRS disciplinary policies; the management of aggressive behaviors; grief/loss issues of children in care; special issues of working with children who have emotional/behavioral problems associated with abuse/neglect or traumatic brain injury; basic training in the concepts of the various diagnostic categories affecting children placed in TFC homes; training in working with biological/adoptive families regarding issues of reintegration or dealing with resolving issues within families that prevent children from living at home; as well as the provision of self-sufficiency or adult living transition skills for children who may not live with family members after treatment.
- In-Service Training shall be on record for each therapeutic family foster parent and shall describe the professional development plan. It is preferred that the individuals chosen as therapeutic family Foster parents will be experienced foster parents, but exceptions can be made to allow "new" individuals to become TFC parents if they demonstrate exceptional parenting abilities. Please see Section III of the National Standards for more discussion regarding training for the TFC parents.
- Placements in each therapeutic family foster home may only be made by the Sponsoring Agency.
- Must notify the Sponsoring Agency of any changes or impending changes in the household/family composition.
- Must participate actively in the treatment plan and attend Case Planning Conferences as established by the Treatment Team.
- Must obtain the Sponsoring Agency's permission to take a child in placement out of state or to move to another residence.
- Work with the schools regarding the education of the child and obtain free textbooks and lunches where applicable. If necessary, the therapeutic family foster parent should become the Educational Advocate for foster children in the home, and attend all Individual Educational Plan conferences, and notify the Sponsoring Agency if there are suspensions or dismissals from school.
- Obtain needed medical/dental/psychiatric care for the child including the KanBeHealthy medical screenings. Medical information as required by licensing regulations should be maintained by the foster parents.
- Incorporate the foster child into the family affording him/her the same privileges and responsibilities of other family members; appropriate to his/her age and abilities.
- Maintain appropriate renters/homeowners/household care insurance and furnish proof of coverage upon request to the Sponsoring Agency.
- Understand that the placing agencies cannot be held responsible for damages done to the therapeutic family foster parent's home, automobile, household furnishings, or other possessions, done by a foster child beyond that available in applicable insurance coverage.
- Utilize Respite Care and Foster Parent Support provided by the Sponsoring Agency.
- Complete Daily Behavioral Logs reflecting progress or lack thereof of the child in attaining the goals of the treatment plan.

Section 8.7: Therapeutic Family Foster Parent Support

Sponsoring Agency must provide intensive support, technical assistance and supervision to all therapeutic family foster parents. Respite care for the therapeutic family foster parents must be planned on at least a monthly basis, and respite should be provided both in planned situations and in crisis situations. Respite shall be provided in homes selected and trained using the same standards for therapeutic family foster parents. Support groups of therapeutic family foster parents should be formed to help in the process of affirming and reinforcing the very central role the therapeutic family foster parents must have in the treatment of severely emotionally disturbed youth.

Section 8.8: Staff Training

Pre-Service and ongoing annual in-service training and support will be mandatory for all staff and respite foster parents working in the TFC program. Annual staff training records will be kept by the TFC program for review by SRS and KDHE. Administrators, Supervisors, Case Coordinators and therapeutic family foster parents will complete the 30 hour PS MAPP training. Additional training shall, at a minimum, consist of: administration of medication; orientation to mandatory abuse /neglect reporting; SRS disciplinary policies; the management of aggressive behaviors; grief /loss issues of children in care; special issues of working with children who have emotional / behavioral problems associated with abuse /neglect or traumatic brain injury; basic training in the concepts of the various diagnostic categories affecting children placed in TFC homes; training in working with biological /adoptive families regarding issues of reintegration or dealing with resolving issues within families that prevent children from living at home; as well as the provision of self-sufficiency or adult living transition skills for children who may not live with family members after treatment.

Section 9: Child's Rights

The staff of the Child Placing Agency and therapeutic family foster parents shall allow privacy for each child. The foster home's space and furnishings shall be designed and planned with respect for the child's right to privacy. The foster home's design shall also provide supervision according to the ages and needs of the children/youth in placement. Contacts between the child/youth and his/her parents or guardian shall be allowed while the child/youth is in care unless the rights of the parents have been terminated by court order or family contact is not in the child's best interest. The frequency of contact shall be determined by the needs of the child/youth and his/her family or guardian.

The Child Placing Agency shall have clearly written policies regarding visits, gifts, mail and telephone calls between the child/youth and his/her family, or guardian. These policies shall be made known to the child/youth and his/her family or guardian prior to admission. Youth shall be allowed to send and receive mail and have telephone conversations with family members or guardian unless the best interest of the youth or a court order necessitates restrictions. If restrictions on communications or visits are necessary these shall be reviewed monthly by a psychiatrist, licensed psychologist or social worker with a master's degree in social work and the referring agency notified.

A youth shall be allowed to bring personal possessions to the therapeutic family foster home and may acquire others. Prior to admission, information shall be made available to the youth and their parents or guardian concerning what possessions a youth may bring to the foster home and the kinds of gifts they may receive.

Section 9.1: Discipline

Discipline shall be consistent with the policies of SRS and shall not be physically or emotionally damaging. Only therapeutic family foster parents or substitute care providers, including respite providers, shall discipline children/youth placed in a TFC home.

Children/youth shall not be:

- Subjected to cruel, severe, unusual or unnecessary punishment.
- Subjected to remarks that belittle or ridicule them or their families.
- Denied food, mail or visits with their families as punishment.
- Punished by shaking, striking or spanking.
- Discipline or control shall fit the needs of each youth.

Section 10: Abuse/Neglect Reporting

Physical Abuse means the infliction of physical harm on a child or the causation of a child's deterioration, or the likelihood of harm or deterioration. K.A.R. 30-46-10

Sexual Abuse means any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include allowing, permitting, or encouraging a child to engage in prostitution or to be photographed, filmed, or depicted in obscene or pornographic material. Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity, or coercion. K.A.R. 30-46-10

Mental or Emotional Abuse means the infliction of mental or emotional harm to a child or the causation of a child's deterioration. This term may include, but shall not be limited to, maltreatment or exploitation of a child to the extent the child's health is likely to be harmed.

This term may include the following:

1. terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;
2. emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child;
3. corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behaviors. K.A.R. 30-46-10

Neglect means any act or omission by a parent, guardian or person responsible for the care of a child resulting in harm to a child or presenting a likelihood of harm and the acts or omissions are not due solely to the lack of financial means of a child's parent or other custodian. Neglect may include but, shall not be limited to:

1. failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;
2. failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or the likelihood of harm to the child; or
3. failure to use resources available to treat a diagnosed medical condition if the treatment will make the child substantially more comfortable, reduce pain and suffering, correct or substantially diminish a crippling condition, or prevent the condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202(t)

As a mandated reporter, a TFC parent must report all witnessed or suspected abuse/neglect to the child/youth's referring case manager/social worker and SRS through the SRS Kansas Protection and Report Center (1-800-922-5330). Abuse is any act or failure to act which results in death, physical harm, emotional harm, or which presents a likelihood of harm to a person under age 18. The broad definition of

abuse includes physical abuse, emotional abuse, and sexual abuse. Neglect is any act or omission resulting in harm to a child or which presents a likelihood of harm. Neglect includes failure to provide food, clothing, shelter, safety, adequate levels of appropriate supervision, medical treatment, or education.

Section 11: Critical Incident

A Critical Incident is an occurrence that requires the provider to make a response that is not a part of the program's ordinary daily routine.

Section 11.1 Critical Incident Reporting

Critical incidents are to be reported to the youth's custodial case manager and the youth's parent or guardian when appropriate.

Each foster care family shall obtain on-call/emergency contact information for all custodial case managers in the event of an emergency or critical incident.

The following critical incidents should be verbally reported immediately with a written report to the custodial case manager within 24 hours of the event (please refer to the following definitions for clarification):

- **Attempted suicide**: The attempt to intentionally kill oneself and the attempt caused injury or could have resulted in serious injury or death if not detected.
- **Suicide**: Intentionally killing oneself.
- **Homicide**: The killing of one person by another.
- **Other death**: Accidental death or death from natural causes of youth.
- **Assault/Battery**: Verbally creating fear of bodily harm and/or the causing bodily harm against another person.
- **Sexual misconduct**: Any sexual conduct between youth or between youth and staff/volunteers. Sexual conduct includes the intentional touching of another person's intimate parts, or the clothing covering the immediate area of the intimate parts, committed with sexual or aggressive intent.
- **Alleged maltreatment of youth**: Any act or situation of abuse and/or neglect, as defined by K.A.R. 30-46-10.
- **Serious youth injury/illness**: Any youth illness that requires the youth to be hospitalized or receive significant medical treatment. Significant medical treatment is treatment that could not be handled by a trained health care person outside of the hospital or clinical setting.
- **Serious infectious disease**: Diseases such as, but not limited to TB, Hepatitis A/B/C, or a serious sexually transmitted disease as tracked by the Center for Disease Control (CDC). This only needs to be reported if there is a threat of transmission of the disease to staff or other youth.
- **Riot/Hostage situation**: Any disturbance by three or more youth that seriously disturbs the operation of a facility, jeopardizes the control of an area, threatens violence against or destruction of property, or results in significant property damage or personal injury to youth or staff. Includes any hostage situation.
- **Natural disaster**: Acts of nature which cause personal injury to staff and/or youth or which causes structural damage to the physical structure housing youth.
- **AWOL**: A youth's departure from a placement or supervision without lawful authority, as defined by K.S.A. 75-712f. This also includes youth while on a supervised off grounds setting (i.e. transports, hospital, and medical visits). Reported verbally to law enforcement and the custodial case manager immediately with a written report to the custodial case manager within 24 hours of the event. An immediate verbal notification is to be made to law enforcement and to the custodial case manager when the youth returns or is located.
- **Other**: Any action or situation which would require a response by law enforcement, the fire

department, an ambulance or another emergency response provider. Incidents in this category would also include any incident not reported in another category and have the potential for significant media coverage.

If the critical incident involves abuse or neglect, the facility must also follow mandated reporting requirements.

All facilities must have procedures for reporting critical incidents to administrative staff and recording critical incidents in the resident files. An administrative file of critical incidents must be kept by facility.

An administrative file shall be kept by the facility documenting critical incidents that is separate from the documentation in the youth's file.

JUVENILE JUSTICE FOSTER CARE (JJFC) STANDARDS

Section 1: General Program Description and Requirements

A Juvenile Justice Foster Care (JJFC) home is a family home in which 24-hour care is provided to juvenile offenders who are in need of out-of-home placement to meet their safety and well-being needs. The home must comply with KDHE licensure requirements, and be sponsored by a licensed child placing agency that contracts with the Juvenile Justice Authority (JJA).

Section 1.1: Program Description

Written policy, procedure, and practice require the Provider's program description to affirm that programs include:

- Cognitive Behavioral training and support for JJFC foster parents
- Cognitive Behavioral training and support for parent/legal guardian/reintegration home
- Cognitive Behavioral training and support for youth
- Skills training for youth
- School-based behavioral interventions and academic support
- Supportive service access and coordination
- Permanency – Future Oriented Planning

The range of services to be delivered to meet the variety of individual needs of the youth shall be clearly defined. The General Program description shall include but not be limited to the goals of the program, youth behavioral management system, job descriptions (responsibilities, functions, and qualifications), policies and procedures, daily living activities, health services, youth rights and responsibilities, visitation policies and service identification and access policies.

Section 1.2: Provider Qualification

1.2.1: Licensure

Written policy, procedure, and practice require current and open licensure by the Kansas Department of Health and Environment as a Child Placing Agency. The Child Placing Agency shall ensure current and open licensure of each home as a Family Foster Home by the Kansas Department of Health and Environment (KDHE) and for youth over 16 years of age that the home meets the same requirements.

- An exception to KDHE requirements for an individual Family Foster Home may be requested by the Child Placing Agency to JJA for youth meeting all of the following criteria:
    - The youth is sixteen (16) years of age or older
    - The proposed Family Foster Home parents have an existing social relationship with the youth and the parent/legal guardian/reintegration home derived from family friendship, neighbors, church, school, etc.
    - The placement is for only the one specific youth and the home consist of only the parent(s) and their biological/adopted children
    - A home study is completed on proposed home which indicates the home to be safe and supportive of the youth
    - The parent/legal guardian/reintegration home agree that placement with this family is in the best interest of the youth

Oversight of the requirements for licensure shall be the responsibility of the Kansas Department of Health and Environment.

1.2.2: Application Process

Written procedure and practice require the Provider to adhere to the JJFC application and contractual process to include:

- Meeting between Provider and JJA to discuss the JJFC model, philosophy, expectations and outcomes
- Submission of JJA Provider Agreement Packet, policy and procedure manual and other documentation for review
- Attendance of a JJA sponsored JJFC training to provide knowledge, skills and materials related to cognitive behavioral practices for case coordinators, foster parents and youth
- Submission of materials to reflect the items in JJFC Standard 1.1
- Final on-site technical assistance to include a review of the training for staff or foster families
- Once the above steps have been finalized, the Provider Contract shall be signed and placement of youth shall begin

Section 2: General Staffing Requirements

Section 2.1: Case Coordinator

Written policy, procedure and practice require staff in addition to licensure requirements to include the position of Case Coordinator. Each Case Coordinator shall:

- Have at least a bachelor's degree in one of the human service fields (social work, psychology, criminal justice, counseling, nursing or education) and a working knowledge of adolescent development principles
- Be at least twenty-one (21) years of age and at least three (3) years older than the oldest youth served
- Not be a person restricted from working with youth as defined by K.S.A. 65-516
- Be responsible for review of the youth's risks and needs and then development and review of an individualized program plan designed to address the youth's risks and needs
- Assist Foster and parent/legal guardian/reintegration home with community resource access
- Provide case coordination for no more than twelve (12) youth
- Identification of existing and development of community based resource
- Case Coordinator duties must be 100% of job function and cannot be combined with duties of positions required by KDHE regulations or other administrative duties

Section 2.2: Foster Parent

Written policy, procedure and practice require each foster parent be at least three (3) years older than the oldest youth served.

Section 2.3: Respite Care Providers

Written policy, procedure and practice shall require that each child placing agency, in addition to complying with KDHE regulations, ensure that respite care homes meet the following requirements:

- Placement capacity in a respite home (either a home providing respite for a JJFC youth or a JJFC home providing respite for a non-JJFC youth) shall not exceed the requirements as set forth in K.A.R. 28-4-712
- Any foster home providing respite care for a JJFC youth shall comply with the requirements for supervision of a JJFC youth, as stated in section 4.1.2

- No JJFC home may provide more than seven (7) calendar days of respite care in a calendar month
- No JJFC youth may be placed in respite care for more than seven (7) calendar days per calendar month
- At no time will a foster home provide respite care for both a JJFC youth and a CINC at the same time

Section 3: Criteria for the Youth's Admission

Section 3.1: Population Served

Written policy, procedure and practice require a description of the population to be served to include males and females ages 10-23 in the custody of the Commissioner of the Juvenile Justice Authority who are appropriate for placement as defined by:

- No current need for Psychiatric Residential Treatment Facility (PRTF)
- Not currently suicidal, homicidal or requiring detoxification services necessitating hospitalization
- Not having exceptional medical needs that cannot be accommodated in a home setting
- Not currently appropriate for reunification to removal home
- No willing relative placement available
- Not capable of living independently or in Community Integration Programs (CIP) or in Transitional Living Programs (TLP)

Section 3.2: Referral and Intake Process

Written policy, procedure and practice require the Provider to respond to referrals within forty-eight (48) hours of their receipt with acceptance of referral for further placement consideration or denial. Upon acceptance for further placement consideration, a face-to-face intake shall be conducted with the youth within three (3) business days which provides an opportunity to review the youth's specific placement needs and answer the youth's questions about the placement and program. The parent/guardian/reunification home shall be invited to participate unless prohibited by court order or specifically requested by the community supervision agency to exclude. The face-to-face intake may be conducted by the case coordinator.

Section 3.3: Placement

Written policy, procedure and practice require placement criteria to include:

- Youth must be placed in homes that have the necessary community resources available to the youth and family
- A Placement Agreement must be completed between the provider and the community supervision agency. A copy of the Placement Agreement must be kept in the youth's file. The initial service authorization period for a JJFC home will be for not more than 90 days. Service extensions will be for a period of time not to exceed 60 days, and will be examined by the youth's custodial case manager to ensure the youth is receiving the services they need to reintegrate into the community.
- Whenever possible, youth should be placed in homes within 100 miles of the removal home. When a youth is placed outside of the 100 mile radius, considerations should be made regarding:
    - Permanency planning and the option for reintegration
    - Availability of vital supportive services
    - Education or employment considerations
    - Accommodation of independent Living needs
- If a youth is placed outside 100 miles, the JJFC Case Coordinator must still meet the contact requirements, as outlined in section 4.1.4

Section 3.4 Resident Lodging

In order to support the daily management and administration of residents, each residential provider shall develop an objective procedure regarding the physical housing of juvenile offenders. Youth placed in a residential setting shall be assigned to a room based upon various factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning rooms shall include (but are not limited to):

- Risk to recidivate (as determined by evidence-based risk assessments)
- Suicidal tendencies
- Level of specialized needs (i.e. mental health, medical, etc.)
- Sex offender status
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc.)
- Vulnerability to being victimized by others (i.e. physical stature)

While each youth will have an individualized program plan, assigning rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and effective management of the living units.

Section 4: Service Delivery

Section 4.1: General Services

4.1.1: Foster Home Beds

Written policy, procedure and practice shall require foster homes to have no more than three (3) youth in placement at any given time. JJFC foster homes shall be limited to the placement of youth in the juvenile justice system.

For the provision of respite care, the provider shall comply with all applicable KDHE regulations as well as applicable qualification standards found in section 2.3 of these standards. No additional approval or review by JJA is required.

The process to evaluate appropriateness of number of youth in a home should include input from the foster parent and the youth's custodial case manager. Factors to be considered may include: YLS/CMI scores; foster parents experience level; quantity, intensity, and frequency of required supports; transportation; number of biological youth in the home; history of youth's behavioral patterns; ages of youth; and complaints to regulatory or investigatory agencies in regard to the foster home.

In no circumstance will it be permissible to grant an exception that exceeds KDHE licensure requirements

4.1.2: Supervision

Written policy, procedure and practice require supervision to be provided twenty-four (24) hours a day, 7 (7) days a week to each youth.

Supervision is defined as direct supervision by a foster parent and/or firsthand knowledge by the foster parent as to the physical location of the youth when participating in approved activities. The foster parent must make arrangements to be notified immediately whenever the youth is not where they are expected to be.

4.1.3: Placement Stability

Written policy, procedure and practice require plans and services to optimize placement stability in one foster home throughout completion of the youth's program plan. Disruption of placement shall require a face-to-face conference including the custodial case manager, foster parent, parent/legal guardian/reintegration home and Case Coordinator. If disruption is recommended a plan for transition shall be developed.

Immediate removal may only be initiated upon youth's emergency admission to inpatient psychiatric or substance use disorder treatment, arrest by Law Enforcement or removal for the safety of the youth by the community supervision agency.

Sustaining a youth in one foster home allows for long-term planning for education and employment, creates mechanisms for staff and foster parents to support youth and their parent/legal guardian/reintegration home, connects youth with a consistent network of adults for guidance, gives youth and families opportunities to build relationships that will assist youth with reintegration into their families or the larger community.

Section 4.1.4 Case Coordinator Contact Requirements

The youth shall have a face-to-face meeting with their case coordinator from the child placing agency a minimum of one time per week.

The JJFC Case Coordinator will have communication with the youth's custodial case manager a minimum of one (1) time per calendar month. This contact may be face-to-face, verbal, written, etc.

The JJFC Case Coordinator will conduct a face-to-face visit with the JJFC Foster Home a minimum of one (1) time per calendar month.

The JJFC Case Coordinator will meet face-to-face with the Removal/Reintegration Home at least one (1) time per calendar month.

Section 4.2: Services to Youth

4.2.1: Service Access

Written policy, procedure and practice require that the Provider will provide services to all youth appropriately referred to the program and meet admission criteria as defined in Section 3.1 of these Standards. Exceptions to this standard are limited to the unavailability of foster beds or the unavailability of a home that can provide for the needs of the individual youth.

Provider should target recruitment and training activities that will focus on identifying foster parents that are interested in working with the target population and have the skills (or potential to develop the skills) to support youth that are likely to be referred. Services provided to youth are to be age appropriate and based on the identified needs of the individual.

4.2.2: Initial Assessment

When a youth enters a JJFC home, the JJFC Case Coordinator shall begin assessing their strengths and needs within twenty-four (24) hours and shall have a completed assessment within 7 days. The assessment shall include but not be limited to the following:

- Reasons for referral to the facility.

- Evaluation or assessment covering the following areas:
    1. physical health
    2. family relations
    3. academic or vocational training
    4. community life
    5. interpersonal interactions
    6. daily living skills
    7. immediate incidental mental health/substance use disorder needs service needs.

If the JJFC provider's pre-placement interview (reference Section 3.2, Referral and Intake Process) contains all of the above components, documentation of this interview may serve as the JJFC provider's Initial Assessment.

4.2.3: Program Planning

Written policy, procedure and practice shall require each youth in foster care be reviewed to identify strengths and risk/needs within twenty-four (24) hours of admission to the foster home. Review documents must be included in the case record. The program plan shall be established by the end of fourteen (14) days and shall address the risk/needs, emotional, physical, educational, social, familial, and where appropriate independent living needs of the youth. It shall be the responsibility of the provider to help the youth successfully complete the plan. Program plans shall be updated whenever new needs are identified or when program goals are met. Program plans should be thoroughly reviewed and revisions made at the case review conferences within thirty (30) days of admission and each thirty (30) days thereafter. Information obtained from the youth, parent/legal guardian/reintegration home, foster parents and custodial case manager shall be considered in the report.

The program plan shall include:

- Long term goals in the areas of reducing risk/needs, physical health, family relations, daily living skills, academic and/or vocational skills, interpersonal relations, and emotional/psychological health
- Short-term goals that will help a youth eventually reach his/her long term goals in each of the above areas
- Specific plans for reaching the short-term goals including services to be provided and frequency
- Estimated time for reaching short-term goals
- The youth's signature and signature of all participants indicating that they have participated in the development of the program plan

4.2.4: Discharge/Aftercare Plan

Written policy, procedure and practice shall require discharge planning begin upon admission of the youth. A discharge plan shall be developed thirty (30) days prior to placement discharge and initial appointments for any identified services set up prior to discharge At a minimum, the youth, parent/legal guardian/reintegration home, foster parents and the custodial case manager should be involved in planning the discharge of a youth from foster care. A discharge summary shall be completed at the time of the youth's discharge and shall accompany the youth upon discharge. The summary shall include:

- Delineation of after-care plans and goals that the youth has reached
- Written recommendations for aftercare
- Recommendations that specify the nature, frequency, and duration of services
- The plan shall also document who the responsible parties are for aftercare services

4.2.5: Daily Living

Written policy, procedure and practice require daily living services to be provided and include the following:

- Room, board, childcare, personal spending money, school fees, and clothing
- Medical care including, but not limited to, vitamins, over-the-counter medications, first aid treatment, or other medical services that are not covered by the Kansas Medicaid Program
- Transportation to appointments, including to and from school, medical care, recreation, home visits and court appearances
- Academic activities – assistance with school work, vocational training, and/or G.E.D. training
- Coordination of passes, home visits to include monitored visits at the placement or in the community where necessary, transportation for parents, and other reasonable accommodations for parents that are necessary to support reunification to the family

4.2.6: Life Skills

Written policy, procedure and practice require the review of the youth's life skills competency upon admission and age appropriate life skill development services to be provided and include but not limited to:

- Personal Hygiene
- Laundry and maintenance of clothing
- Appropriate social skills
- Housekeeping
- Appropriate use of recreation and leisure time
- Use of community resources
- Money management
- Use of transportation
- Budgeting and shopping
- Cooking
- Employment related matters (punctuality, interviewing, attendance)
- Vocational planning

4.2.7: Educational Support

Written policy, procedure and practice require that all youth will participate in traditional educational pursuits. Alternatives such as GED shall not be pursued without the approval of the parent/legal guardian/reintegration home and custodial case manager. All education programs must be approved by the Kansas State Department of Education. Input as to the appropriateness for the youth shall be obtained from the school district, youth and foster parent. Educational services to be provided include but not limited to:

- Enrollment in school system or other approved education program for all youth of mandatory school age
- Participate in IEP/504 team
- Attend Parent/Teacher meetings
- Arrange for or directly provide tutoring as necessary
- Design and implement future educational/vocational plans
- Explore and facilitate post-secondary education , if appropriate (college, technical college, trade school, college financial aid access)

4.2.8: Employment Support

Written policy, procedure and practice require employment services to be provided and include but not limited to:

- Employment or job search efforts to be required when youth is not involved in educational endeavors
- Access community resources to obtain or sustain youth's employment

4.2.9: Self-Advocacy

Written policy, procedure and practice require self-advocacy education for all youth in foster care. Curriculum should include but not limited to:

- Setting goals, short and long-term
- Researching – how to find facts and relevant information
- Analyzing facts and information
- Connecting personal goals with others' goals
- Identifying allies and supporters
- Critical analysis of situations
- Identifying self-strengths and needs
- Planning strategy
- Planning written and oral presentations
- Dealing with setbacks and rejection
- Building on successes
- Reviewing and adjusting goals and strategies

Self-advocacy education is a skill youth can learn and use to plan for their futures. For it to work effectively, foster care youth need placement environments that support planning for the future and practicing self-advocacy. The primary goal is to prepare youth for a future in which they are participating citizens.

Section 4.3: Accessing Outpatient Mental Health/Substance Use Disorder Services

Only Outpatient Mental Health/Substance Use Disorder services are allowed while a youth is residing in an out of home placement (excluding PRTF placement). If outpatient services are needed, the provider shall coordinate assessments and services through SRS behavioral health managed care program associates of the Prepaid Ambulatory Health Plan (PAHP) and/or of the Prepaid Inpatient Health Plan (PIHP). The PAHP and PIHP associates will determine the type, frequency and duration of services required to meet the individualized Mental Health/Substance Use Disorder needs of each youth.

Upon admission or during the course of the youth's stay, if the youth begins to exhibit behavior/needs which cannot be addressed by the placement or through outpatient services, the provider shall collaborate with the custodial case manager to obtain an appropriate screen/assessment to determine the level of services required.

If the youth is receiving Mental Health/Substance Use Disorder services from a PAHP or PIHP associate, including a community mental health center or independent practitioner, at the time of admission, the youth may continue services by the same provider to maintain continuity of service.

Providers may employ, contract or otherwise partner with associates of the PAHP and/or PIHP to provide Outpatient Mental Health/Substance Use Disorder services to youth residing at the program.

Providers shall not prohibit the youth's ability to request or receive services from any willing provider

who are authorized associates of the PAHP or PIHP.

Section 4.4: Services to Foster Families

Written policy, procedure and practice require supportive services to foster families to include but not limited to:

- Crisis Support 24 hours a day – 7 days a week
- Respite Care
- Access to support groups with other foster families
- Skill development opportunities
- Mechanism to allow feedback regarding the adequacy of support services received

Section 4.5: Services to Parent/Legal Guardian/Reintegration Home

Written policy, procedure and practice require supportive services to parent/legal guardian/reintegration home while the youth is in placement include but not limited to:

- Parent training (consistent discipline, supervision and encouragement)
- Mechanism for information sharing
- Cognitive Behavioral training
- Matching family resources (implement supportive services that can be replicated in the home)
- Crisis support during home visits
- Resource accessing for family therapy
- Assess level of awareness and level of commitment to drive interventions and address responsivity factors

Section 5: Resident's Rights

The foster family shall allow privacy for each youth. The home's space and furnishings shall be designed and planned with respect for the youth's right to privacy. The home's design shall also provide supervision according to the ages and needs of the youth. Each youth shall have a quiet area where they can withdraw from the group when appropriate.

Contacts between the youth and their parents/guardian shall be allowed while the youth is in care unless the rights of the parents have been terminated by court order or family contact is not in the youth's best interest. The frequency of contact shall be determined by the needs of the youth and his/her family or guardians per program plan requirements.

The JJFC provider shall have clearly written policies regarding visits, gifts, mail, E-mail and telephone (including cell phone) calls between the youth and their family, or guardian. These policies shall be made known to the youth and his/her family/guardian at or prior to admission.

Youth shall be allowed to send and receive mail and have telephone conversations with family members/guardians unless it is not in the best interest of the youth, the safety and security of home, or if a court order necessitates restrictions.

If restrictions on communications or visits are necessary these shall be documented in the youths program plan and reviewed at the 30-day case reviews. The youth's custodial case manager must be notified of any new restrictions to communications or visitation implemented by the facility prior to its implementation.

A youth shall be allowed to bring personal possessions to the foster home and may acquire other possessions in accordance with the policies of the JJFC Provider. Prior to admission, information shall be

made available to the youth and their parents/guardians concerning what possessions a youth may bring to the home and the kinds of gifts they may receive. Possessions which a youth cannot have or receive at the facility shall be specified in writing and distributed to the youth and their parents/guardians.

Discipline at the foster home shall be consistent and not be physically or emotionally damaging. Youth shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Youth shall not be subjected to remarks that belittle or ridicule them or their families. Youth shall not be denied food, mail, or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. Only foster parents shall discipline the youth.

Section 6: Special Circumstances Affecting Youth in Placement

Section 6.1: Time Out

A procedure used to assist the individual to regain emotional control by removing the individual from his or her immediate environment and restricting the individual to a quiet area or unlocked quiet room.

Application of time out:

1. A youth in time out must never be physically prevented from leaving the time out area.
2. Time out may take place away from the area of activity or from other residents.
3. Foster Parents must monitor the youth while he or she is in time out.

Section 6.2: Reporting Abuse/Neglect

Physical Abuse means the infliction of physical harm on a child or the causation of a child's deterioration, or the likelihood of harm or deterioration. K.A.R. 30-46-10

Sexual Abuse means any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include allowing, permitting, or encouraging a child to engage in prostitution or to be photographed, filmed, or depicted in obscene or pornographic material. Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity, or coercion. K.A.R. 30-46-10

Mental or Emotional Abuse means the infliction of mental or emotional harm to a child or the causation of a child's deterioration. This term may include, but shall not be limited to, maltreatment or exploitation of a child to the extent the child's health is likely to be harmed.

This term may include the following:

1. terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;
2. emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child;
3. corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behaviors. K.A.R. 30-46-10

Neglect means any act or omission by a parent, guardian or person responsible for the care of a child resulting in harm to a child or presenting a likelihood of harm and the acts or omissions are not due solely to the lack of financial means of a child's parent or other custodian. Neglect may include but, shall not be limited to:

1. failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;

2. failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or the likelihood of harm to the child; or
3. failure to use resources available to treat a diagnosed medical condition if the treatment will make the child substantially more comfortable, reduce pain and suffering, correct or substantially diminish a crippling condition, or prevent the condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202(t)

Section 6.3: Mandated Reporters

Mandated reporters must report all witnessed or suspected abuse/neglect to SRS through the SRS Kansas Abuse/Neglect Hotline.

K.S.A. 38-2223 states that when any of the following persons has reason to suspect that a child has been harmed as a result of physical, mental or emotional abuse or neglect or sexual abuse, the person shall report the matter promptly:

A. The following persons providing medical care or treatment: Persons licensed to practice the healing arts, dentistry and optometry; persons engaged in postgraduate training programs approved by the state board of healing arts; licensed professional or practical nurses; and chief administrative officers of medical care facilities;

B. the following persons licensed by the state to provide mental health services: Licensed psychologists, licensed masters level psychologists, licensed clinical psychotherapists, licensed social workers, licensed marriage and family therapists, licensed clinical marriage and family therapists, licensed professional counselors, licensed clinical professional counselors and registered alcohol and drug abuse counselors;

C. teachers, school administrators or other employees of an educational institution which the child is attending and persons licensed by the secretary of health and environment to provide child care services or the employees of persons so licensed at the place where the child care services are being provided to the child; and

D. firefighters, emergency medical services personnel, law enforcement officers, juvenile intake and assessment workers, court services officers and community corrections officers, case managers appointed under K.S.A. 23-1001 et seq., and amendments thereto, and mediators appointed under K.S.A. 23-602, and amendments thereto.

Abuse/neglect reported or witnessed in any JJFC Foster Home must be immediately reported to the youth's custodial case manager and SRS through the SRS Kansas Abuse/Neglect Hotline (1-800-922-5330). The Abuse/Neglect Hotline number must be posted in a prominent place in the foster home. Any employee of the provider or a parent in the JJFC foster home who witnesses or hears about the abuse/neglect of a resident within that home is to notify the Director of the JJFC Provider immediately, except in cases where the alleged perpetrator is the Director. The Director is responsible to see to it that all cases of abuse/neglect are reported to them and are passed on to the resident's custodial case manager and SRS through the SRS Kansas Abuse/Neglect Hotline. At no time shall the administration of a program in which abuse/neglect has allegedly occurred interfere or otherwise attempt to alter the report of an abuse/neglect claim made by an employee of that facility.

Section 6.4: Critical Incident Reporting

Critical incidents are to be reported to the youth's custodial case manager and the youth's parent or guardian when appropriate.

"Each JJFC provider shall develop an internal process for obtaining on-call/emergency contact information for all custodial case managers in the event of an emergency or critical incident."

The following critical incidents should be verbally reported immediately with a written report to the custodial case manager within twenty-four (24) hours of the event (please refer to the following definitions for clarification):

- **Attempted suicide**: The attempt to intentionally kill oneself and the attempt caused injury or could have resulted in serious injury or death if not detected.
- **Suicide**: Intentionally killing oneself.
- **Homicide**: The killing of one person by another.
- **Other death**: Accidental death or death from natural causes of youth.
- **Assault/Battery**: Verbally creating fear of bodily harm and/or the causing bodily harm against another person.
- **Sexual misconduct**: Any sexual conduct between youth or between youth and staff/volunteers. Sexual conduct includes the intentional touching of another person's intimate parts, or the clothing covering the immediate area of the intimate parts, committed with sexual or aggressive intent.
- **Alleged maltreatment of youth**: Any act or situation of abuse and/or neglect, as defined by K.A.R. 30-46-10.
- **Serious youth injury/illness**: Any youth illness that requires the youth to be hospitalized or receive significant medical treatment. Significant medical treatment is treatment that could not be handled by a trained health care person outside of the hospital or clinical setting.
- **Serious infectious disease**: Diseases such as, but not limited to TB, Hepatitis A/B/C, or a serious sexually transmitted disease as tracked by the Center for Disease Control (CDC). This only needs to be reported if there is a threat of transmission of the disease to staff or other youth.
- **Riot/Hostage situation**: Any disturbance by three or more youth that seriously disturbs the operation of a facility, jeopardizes the control of an area, threatens violence against or destruction of property, or results in significant property damage or personal injury to youth or staff. Includes any hostage situation.
- **Natural disaster**: Acts of nature which cause personal injury to staff and/or youth or which causes structural damage to the physical structure housing youth.
- **AWOL**: A youth's departure from a placement or supervision without lawful authority, as defined by K.S.A. 75-712f. This also includes youth while on a supervised off grounds setting (i.e. transports, hospital, and medical visits). Reported verbally to law enforcement and the custodial case manager immediately with a written report to the custodial case manager within 24 hours of the event. An immediate verbal notification is to be made to law enforcement and to the custodial case manager when the youth returns or is located.
- **Other**: Any action or situation which would require a response by law enforcement, the fire department, an ambulance or another emergency response provider. Incidents in this category would also include any incident not reported in another category and have the potential for significant media coverage.

If the critical incident involves abuse or neglect, the foster home must also follow mandated reporting requirements.

All foster homes must have procedures for reporting critical incidents to administrative staff and recording critical incidents in the resident files. An administrative file of critical incidents must be kept by the foster home.

An administrative file shall be kept by the foster home documenting critical incidents that is separate from the documentation in the youth's file.

Section 7: Training

Section 7.1: Specialized Training

Written policy, procedure and practice require training for staff and foster parents, which is in addition to the hours and subjects necessary to satisfy licensure requirements of the Kansas Department of Health and Environment, as specified in this section. These trainings are essential to the effective delivery of the specialized programming of this service type and to meeting the specific needs of the juvenile offender population.

Section 7.2: Approval of Cognitive Training Curriculum

Written policy, procedure and practice require any staff person who will provide training to case coordinators, foster parents, or others on the cognitive behavioral practices implemented by the Provider to have completed a sixteen (16) hour training provided and/or approved by the Kansas Juvenile Justice Authority. From this sixteen (16) hour training, the provider will develop a twelve (12) hour training on the cognitive behavioral practices to be delivered to case coordinators, JJFC foster parents and any other JJFC staff (see section 7.3 for further explanation on cognitive behavioral training topics). The final step in the JJFC training curriculum certification process is to deliver the 12 hour training to JJFC provider staff within three (3) months of completing the initial 16-hour training. A Kansas Juvenile Justice Authority representative will attend this first training to certify that the cognitive behavioral curriculum is being delivered with fidelity.

Section 7.3: Initial Foster Parent Training

Written policy, procedure and practice require each foster parent to have completed twenty (20) hours of training, prior to the placement of any youth into their home. The hours are minimum requirements.

- Twelve (12) contact hours of training in the Cognitive Behavioral practices provided/approved by the Juvenile Justice Authority for use by the Child Placing Agency. The topics must include the following: cognitive theory, social learning theory, the cognitive behavioral cycle, cognitive restructuring, tools for restructuring, cognitive skill building, and effective reinforcements. The training must include knowledge building and skill development. Participation in the training specified in section 7.2 may substitute for this requirement.
- One (1) contact hour of Adolescent Growth and Development and Sexual Development which shall address biological, psychological and cognitive changes in youth during the adolescent years to include but not limited to: physical changes to the body; mental development such as the ability to think abstractly, expressing concerns about philosophy, politics and social issues, thinking long term and setting goals, comparing oneself to one's peers; and social development such as desire for independence from parents, peer influence and acceptance, male-female relationships
- One (1) contact hour of Crisis Prevention and Response to include the identification and reduction of risk to youth as well as appropriate responses by staff and foster parents in the following areas: changes in youth behavior; interactions with peers, teachers and other persons of influence upon the youth; youth responses to parenting, social situations or life circumstances.
- Two (2) contact hours of Working with Youth with Interagency Involvement, Special Needs and Disabilities which shall address working collaboratively with various agencies on behalf of the youth in foster care, such as schools, courts, supervision agencies and service providers and including effective advocacy for the youth; how to respond to and manage the unique circumstances of youth including issues or removal from the home, school transitions, loss of connections to pro-social friends or organizations and/or special needs because of a specific physical or mental limitations of the youth; how to address warning signs or indicators that may necessitate a specific referral for assessment and the routine support and management of youth with an identified learning disability; and the rights of youth and responsibilities of public

education systems to serve this population.

- Two (2) contact hours of training on Gangs, which shall include information to assist the foster parents in the identification of potential gang activity by youth in their home to include, but not limited to the use of language, displaying of colors, specific dress, behavior of youth and/or peers and graffiti.
- Two (2) contact hours of training on Substance Use Disorders to include knowledge and skills focused on the identification of possible drug use by youth, supporting youth in maintaining abstinence, supporting youth during treatment, and effectively responding to drug use by a youth.

If a Foster Parent/Family completes the PS-MAPP curriculum in full, JJA will consider an exception to allow the PS-MAPP curriculum to meet the requirements for the following: Adolescent Growth and Development and Sexual Development; and Working with Youth with Interagency Involvement, Special Needs and Disabilities. However, to be considered, the curriculum must include topics on sexual development and working with the courts and supervision agency. An exception must be submitted to JJA Central Office for this consideration, which should include supporting documentation for the training exception.

Section 7.4: Initial Case Coordinator Training

Written policy, procedure and practice require each case coordinator to have completed thirty (30) hours of training, prior to assuming the case coordinator responsibilities for any youth in placement. The hours are minimum requirements.
Case coordinators must complete the same trainings required of foster parents to ensure they have a comprehensive understanding of the training and are fully capable of supporting those foster parents. In addition to completing the trainings listed in section 7.3, the case coordinator must also complete the following:

- Twelve (12) contact hours of training in the Cognitive Behavioral practices provided/approved by the Juvenile Justice Authority for use by the Child Placing Agency. The topics must include cognitive theory, social learning theory, the cognitive behavioral cycle, cognitive restructuring, tools for restructuring, cognitive skill building, and effective reinforcements. The training must include knowledge building and skill development. Participation in the training specified in section 7.2 may substitute for this requirement.
- One (1) contact hour of Family System Theory which shall include the interaction between family members and the importance of family relationships in overall psychological health.
- Two (2) contact hours of Local Service Systems in Kansas which shall include at a minimum how to access the delivery systems in Kansas for mental health, medical, dental, educational, and substance use disorder services.
- Three (3) contact hours of Program Planning, Permanency Planning and Transition Planning which shall address the development of effective plans including targeting the dynamic risk factors for offending, the development of SMART objectives incorporating the coordination and delivery of services, timeframes and legal aspects of permanency, identification of transition needs and services for development of effective transitional plans from JJFC.
- One (1) contact hour of Cultural Sensitivity and Responsiveness which shall include the development of an understanding of different cultural aspects of each youth and their reunification family, how to approach cultural differences of the foster and reunification home, and to support the youth in maintaining their culture.
- Three (3) contact hours of Working with Sex Offenders which shall address myths and facts of juvenile sex offenders, effective treatment modalities, legal obligations of adjudicated sex offenders for registration and compliance with court orders, and effective supervision and management practices of sex offenders in the community.

If the case coordinator has completed the above trainings within the last twelve (12) months, appropriate documentation of the training completion will suffice to meet these training requirements.

Section 7.5: Foster Parent Training for Sex Offenders

Written policy, procedure and practice require that any foster home who accepts youth who have been adjudicated for a sex crime to have completed additional training specified in this standard, prior to the placement of any adjudicated juvenile sex offender youth into their home. The hours are minimum requirements.

- Three (3) contact hours of Working with Sex Offenders which shall address myths and facts of juvenile sex offenders, effective treatment modalities, legal obligations of adjudicated sex offenders for registration and compliance with court orders, and effective supervision and management practices of sex offenders in the community.

Section 7.6: Annual Training for Case Coordinators

Written policy, procedure and practice require each case coordinator to complete a minimum of twenty (20) hours of annual training. These hours are in addition to any KDHE licensure requirements and shall address the same topics as 7.4. Annual training must be completed in the year between the person's first and second anniversary dates of becoming a Case Coordinator, and annually thereafter.
The training should be designed and structured to continually increase the knowledge basis and skill development of the case coordinator. The training topics shall include:

- The practicing of cognitive restructuring and cognitive skill building
- The use of reinforcements to change behavior
- Recent developments in the treatment and management of adolescent sex offenders, substance use disorder offenders, and offenders with mental health issues.

Section 7.7: Annual Training for Foster Parents

Written policy, procedure and practice require each foster parent to complete a minimum of twelve (12) hours of annual training. These hours are in addition to any KDHE licensure requirements and shall address the same topics as 7.3 and 7.5. Annual training must be completed in the year between the person's first and second anniversary dates of becoming a JJFC foster parent, and annually thereafter.

The training should be designed and structured to continually increase the knowledge basis and skill development of the foster parents.

- The practicing of cognitive restructuring and cognitive skill building
- The use of reinforcements to change behavior
- Recent developments in the treatment and management of adolescent sex offenders, substance use disorder offenders, and offenders with mental health issues.

Section 8: Reporting and Record Keeping

Section 8.1: Youth's File

The family foster home shall maintain a file for each youth in placement. The file shall contain the following information:

- Youth's name and date of birth
- Name and address of the youth's referring agency case manager
- Placement Agreement
- Medical and surgical consents

- Medical and dental records
- Record of youth's prescription and non-prescription medications and when administered
- Authorization for release of confidential information
- Log of critical incident reports

Section 8.2: 30-Day Progress Reports

Thirty-day progress reports shall document youth's adjustment in the home, school performance (if school age), medical, dental, vision, and mental health appointments, critical incidents reported, interactions with parents, and any other significant events or issues related to the youth and the placement.

Section 8.3: Transfer of Youth's Medical Records

When a youth leaves a family foster home to return home or moves to another out of home placement, the youth's medical records shall be given to the youth's referring agency to accompany the youth.

Section 8.4: Record Keeping Requirements for the Foster Home

The record keeping requirements of K.A.R. 28-4-272 shall be met by the foster home.

- Record Retention: Case records, including medical records, shall be maintained six (6) years from the date of the youth's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

- Health Records: Health Care records of residents must meet the requirements of K.A.R. 28-4-275.

- Chart Documentation: A dated record of daily observations and significant occurrences involving each youth shall be maintained. The record shall include events which may affect the well-being of the youth. The record shall be available for review. Each report shall include the date and time of occurrence, the foster parent and/or youth involved, the nature of the incident and the circumstances surrounding it.

Section 8.5: Exception Requests

Written policy, procedure and practice shall require that any request for exception to these standards be submitted to JJA for review and approval at least one (1) week prior to the proposed effective date. The request shall be in writing submitted to the Integrated Services and Programs (ISP) Unit Director. The request shall include but is not limited to the following:

- Explanation of the reason for the exception
- Citation of the specific standard(s) to which the request applies
- If specific to a staff member, the name of the staff person subject to the request
- If specific to a youth, the name of any youth(s) subject to the request
- Proposed effective date and duration of the exception request

Section 9: Performance Measures

The measures for this standard are tracked and calculated by contracted service provider, not individual foster homes. Data will be reviewed annually as part of the renewal of each JJFC provider contract. Where providers are deficient in meeting outcomes technical assistance will be available and the opportunity for a program improvement plan to be developed by the JJFC provider to achieve outcomes in the following year.

- At least 95% of admissions will have the goal to reunify the youth with parent/legal guardian/reintegration home

Calculated as: placement goal identified in the youth's program plan, divided by total admissions to JJFC.

Data will be obtained through review of program plans by JJA staff during technical assistance site visits conducted at least annually.

- At least 75% of releases will be to the parent/legal guardian/reintegration home or to an independent living setting (transitional living program, community reintegration program or independent living)

Calculated as: The total number of youth released to placements of the parent/legal guardian/reintegration home, transitional living, community reintegration program and independent living, divided by all releases from the program.

Data will be tracked through CASIMS by comparing youth placed in JJFC to their next placement type.

In addition to these initial outcomes, JJA will be implementing data collection and monitoring of provider compliance with standards, program effectiveness tools and post release measures of recidivism which may be incorporated into this service as these become reliable data sets.

YOUTH RESIDENTIAL CENTER I STANDARDS

Section 1: General Program Description and Requirements

A Youth Residential Center (YRC) I facility is a 24-hour group boarding home or residential facility that meets the requirements of K.A.R. 28-4-268-280. It is a non-secure residential service designed to provide an environment that will enhance the youth's ability to achieve a higher level of functioning while avoiding future placement in a more highly structured treatment facility.

Section 1.1: Services Provided in Youth Residential Center

The range of services to be delivered by the YRC I facility to meet the variety of individual needs of the residents shall be clearly described. The General Program description approved by SRS Children and Family Services or JJA for each facility shall include but not be limited to the goals of the program, resident behavioral treatment system, job descriptions (responsibilities, functions, and qualifications needed by the person filling the position), policies and procedures, daily living activities, health services, recreation activities, and visitation policies.

Section 2: General Staffing Requirements

Twenty-four hour care which has been licensed by KDHE (K.A.R. 28-4-268-280) in the appropriate licensure category to cover the programming the facility will provide to the populations of children/youth whom the facility will serve. If licensened as a residential center there shall be 24-hour awake staff to insure child safety.

Section 3: Criteria for the Youth's Admission

Population served is children and youth, ages 6 through 22, who:

- Display a need for more structure and supervision than provided in a family foster home due to behaviors which might include difficulty with authority figures, minor offenses and difficulty in school.
- YRC I facilities may also serve those children and youth in Police Protective Custody.
- Children who DO NOT meet the standard for Psychiatric Residential Treatment Facility (PRTF) admission, who are not in need of intensive treatment, and for whom family based services are not appropriate to meet the youth's needs.
- Youth awaiting a PRTF screen may reside in a YRC I until the time of the screen.
- If a youth is in a YRC I awaiting a screen, the screen must be completed within fourteen (14) days, but should be completed as soon as possible. If the youth screens into a PRTF, they can stay up to 14 days while awaiting a PRTF bed.
- No more than 50 percent of the youth in a YRC I facility may have screened into a PRTF and be in the 14-day waiting period for a PRTF placement.
- Youth may step down to a YRC I from a PRTF after the screener and treatment team have determined the youth no longer needs the level of care provided by a PRTF.

Section 3.1: Placement Agreement

A Placement Agreement must be completed between the provider and the referring agency. A copy of the Placement Agreement must be kept in the youth's file at the facility.

The initial service authorization period for a YRC I will be for not more than 90 days. Service extensions will be for a period of time not to exceed 60 days, and will be examined by the youth's custodial case manager to ensure the youth is receiving the services they need to reintegrate into the community. The

youth may continue receiving services in the YRC I facility as long as they continue to require this level of care as determined by the youth's custodial case manager.

Section 4: Resident Lodging

In order to support the daily management and administration of residents, each residential provider shall develop an objective procedure regarding the physical housing of juvenile offenders. Youth placed in a residential setting shall be assigned to a room based upon various factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning rooms shall include (but are not limited to):

- Risk to recidivate (as determined by evidence-based risk assessments)
- Suicidal tendencies
- Level of specialized needs (i.e. mental health, medical, etc.)
- Sex offender status
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc.)
- Vulnerability to being victimized by others (i.e. physical stature)

While each youth will have an individualized program plan, assigning rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and effective management of the living units.

Section 5: Residential Care Program

Section 5.1: Residential Care System

Each YRC I shall have a written program of consistent rules and regulations guiding and governing the daily behavior of the youth under the care of the program. The behavior management system should include a description of daily general routines of the program. The system of rules, rewards, and consequences for given behaviors should be identified. Each youth shall be oriented to the YRC I's behavior management system by a staff member during the admission or orientation process. Notation should be made in the youth's file and signed by the youth that the rules and regulations, rewards and consequences have been discussed with the youth.

The YRC I facility should also post the behavior management system in a common area where youth are able to easily access the system or the youth should be given a written copy of the system to use as a reference. The system should include rules governing interpersonal interactions with staff and peers, facility leave policies, school attendance and behavior while at school, verbal and physical aggression, allowable possessions, awakening and bedtime hours, leisure hours, visitation policies, AWOL attempts, involvement in recreation and other activities, self-destructive behaviors, sexuality, communications with family and others outside the program, religious worship, involvement in therapies, theft, property destruction, behaviors resulting in mandatory removal from the program, and behaviors at the program which could result in legal prosecution.

The overarching goals should be to not only help the youth adjust to the residential facility but also to daily life within society. A resource list shall be maintained by the facility of the available resources to meet the youth's needs in the community.

Section 5.2: Education Requirement

All facilities shall have an education agreement with a school district certified by the state board of

education. The facility shall ensure routine communications between the staff and any educational program in which the youth is placed. This may include requesting and participating in the development of an Individual Education Plan for each resident when appropriate. These contacts shall be noted in the youth's case record.

Section 5.3: Scope of Services

The provider shall write a policy and procedure manual for the operation of the YRC I facility that will be reviewed and approved by SRS Children and Family Services and the Juvenile Justice Authority. It will provide a program for youth in the facility that covers the following program components:

Daily Living Services - Daily living services shall be provided and include the following:

- Room, board, child care, personal spending money, and school fees.
- Transportation to appointments within a 60-mile radius; including to and from school, medical care, recreation, etc.
- Academic activities - assistance with school work, vocational training, and/or G.E.D. training.

Situational Training- to include but not limited to:

- Personal Hygiene – Teaching about body cleanliness, use of deodorants and cosmetics, appropriate clothing, choosing clothing to fit individual and occasion, and keeping clothes neat and clean.
- Health - Identifying and understanding residents' health needs; securing and utilizing necessary medical treatment including preventive and health maintenance services; gaining information and education in health maintenance (including preventive measures, nutrition, menstruation, rest, cleanliness, family planning, drugs, sexually transmitted diseases, exercise, and motivation for meeting own health needs), maintaining contact with providers of health services (physician, nurse, clinic) and using outside resources for assistance (clinics, pharmacies, hospitals).
- Consumer education for independent living- Budgeting, comparative buying, installment buying, avoiding risks, identifying illegal or excessive interest rates, use of credit, avoiding or dealing with debts, using checking and savings accounts, and paying taxes.

Communication skills:

The youth's articulating thoughts and feelings through appropriate use of such skills as speech, writing, and use of the telephone.

Home Management:

Making the bed and changing linens, using the vacuum cleaner, dusting, organizing belongings, disposing of trash, cleaning all areas of the home, operating appliances, cooking complete meals, making simple repairs, who to call when a major repair is needed, being aware of the need for upkeep, handling emergencies, knowing first aid.

Situational Guidance:

Identifying and accepting strengths, developing patterns of acceptance and coping with authority figures, getting along with others, sharing responsibility, being considerate of others, developing friendships, knowing when to go home when visiting, recognizing or modifying attitudes toward self or others, responsible work attitudes, tolerance of verbal criticism, reactions to praise, punctuality, and attendance.

Recreation:

Participating in leisure time activities, learning how to spend leisure time, developing outside activities, managing time, finding recreation with little or no expense involved, finding community projects to take part in, participating in social groups, participating in sports and games, arts and crafts, and appreciating fine arts.

The daily schedule shall address the needs of the residents and the use of time to enhance the resident's physical, mental, emotional, and social development. The facility shall provide supervised indoor and outdoor recreation so that every resident may participate. Age appropriate equipment to promote physical development and physical fitness shall be available. Age appropriate socialization shall be provided utilizing community resources to assist the youth in transitioning back into their community when appropriate.

Section 5.4: Initial Assessment

When a youth enters the facility, the YRC I shall begin assessing their strengths and needs within twenty-four (24) hours and shall have a completed assessment within 7 days. The assessment shall include but not be limited to the following:

- Reasons for referral to the facility.
- Evaluation or assessment covering the following areas:
    1. physical health
    2. family relations
    3. academic or vocational training
    4. community life
    5. interpersonal interactions
    6. daily living skills
    7. immediate incidental mental health/substance use disorder needs service needs.

Section 5.5: Accessing Outpatient Mental Health/Substance Use Disorder Services

Only Outpatient Mental Health/Substance Use Disorder services are allowed while a youth is residing in an out of home placement (excluding PRTF placement). If outpatient services are needed, the provider shall coordinate assessments and services through SRS behavioral health managed care program associates of the Prepaid Ambulatory Health Plan (PAHP) and/or of the Prepaid Inpatient Health Plan (PIHP). The PAHP and PIHP associates will determine the type, frequency and duration of services required to meet the individualized Mental Health/Substance Use Disorder needs of each youth.

Upon admission or during the course of the youth's stay, if the youth begins to exhibit behavior/needs which cannot be addressed by the placement or through outpatient services, the provider shall collaborate with the custodial case manager to obtain an appropriate screen/assessment to determine the level of services required.

If the youth is receiving Mental Health/Substance Use Disorder services from a PAHP or PIHP associate, including a community mental health center or independent practitioner, at the time of admission, the youth may continue services by the same provider to maintain continuity of service.

Providers may employ, contract or otherwise partner with associates of the PAHP and/or PIHP to provide Outpatient Mental Health/Substance Use Disorder services to youth residing at the program.

Providers shall not prohibit the youth's ability to request or receive services from any willing provider who are authorized associates of the PAHP or PIHP.

Section 5.6: Program Plan

For each youth residing in a YRC I for more than 14 days a program plan must be developed based on a thorough assessment. Assessment documents must be included in the case record. The program plan shall be established by the end of 14 days and shall address identified needs in the emotional, physical, educational, social, familial, and where appropriate independent living skill domain of the particular case. Youth may not have identified needs in every domain. If so, note that no needs were identified.

Program plans should be thoroughly reviewed and revisions made at least quarterly. The program plan shall include:

- Long term goals in the areas of physical health, family relations, daily living skills, academic and/or vocational skills, interpersonal relations, and emotional/psychological health.
- Short term goals which will help a youth eventually reach his/her long term goals in each of the above areas.
- Specific plans for reaching the short-term goals including services to be provided and frequency.
- Estimated time for reaching short term goals.
- The youth's signature indicating that the youth has participated in the development of the program plan.

Section 5.7: Discharge/Aftercare Plan

Discharge planning shall begin upon admission of the youth to the facility. At a minimum, the resident, the resident's parents or guardian, and the placing agency should be involved in planning the discharge of a resident from the facility. The discharge plan and modifications to it should be noted in the file.

A discharge summary shall be completed at the time of the youth's discharge. This shall include delineation of after-care plans and goals which the youth have reached. Written recommendations for aftercare shall be made and should specify the nature, frequency, and duration or services the facility recommends for the youth. The plan shall also document who the responsible parties are for aftercare services.

Section 5.8: Case Coordination

Case Coordination in a YRC I shall be carried out by the custodial case manager.

Section 5.9: Home Visits

When home visits are a part of the program plan, there shall be pre and post home visit contacts between the youth, their family, and facility program staff regarding the home visit including pre and post written documentation on the home visit. Because the goal of placement is to return the youth to a family-like setting, it is important that home visits be carefully planned and executed in the best interests of permanency planning for the youth. All home visits shall be arranged through coordination with the youth's custodial case manager.

Section 6: Resident's Rights

The staff of the facility shall allow privacy for each youth. The facility's space and furnishings shall be designed and planned with respect for the resident's right to privacy. The facility's design shall also provide supervision according to the ages and needs of the residents. Each resident shall have a quiet area where they can withdraw from the group when appropriate.

Contacts between the resident and their parents/guardian shall be allowed while the resident is in care unless the rights of the parents have been terminated by court order or family contact is not in the

resident's best interest. The frequency of contact shall be determined by the needs of the resident and his/her family or guardians per program plan requirements.

The facility shall have clearly written policies regarding visits, gifts, mail, E-mail and telephone (including cell phone) calls between the resident and their family, or guardian. These policies shall be made known to the resident and his/her family/guardian at or prior to admission. Residents shall be allowed to send and receive mail and have telephone conversations with family members/guardians unless it is not in the best interest of the youth, the safety and security of facility, or if a court order necessitates restrictions.

If restrictions on communications or visits are necessary these shall be documented in the youth's program plan. The youth's custodial case manager must be notified of any new restrictions to communications or visitation implemented by the facility prior to its implementation.
A resident shall be allowed to bring personal possessions to the facility and may acquire other possessions in accordance with the policies of the facility. Prior to admission, information shall be made available to the youth and their parents/guardians concerning what possessions a youth may bring to the facility and the kinds of gifts they may receive. Possessions, which a youth cannot have or receive at the facility, shall be specified in writing and distributed to the youth and their parents/guardians.

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Youth shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Youth shall not be subjected to remarks that belittle or ridicule them or their families. Residents shall not be denied food, mail, or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. Only staff members shall discipline residents.

Section 7: Special Circumstances Affecting Youth in Residential Placement

Section 7.1: Time Out

A procedure used to assist the individual to regain emotional control by removing the individual from his or her immediate environment and restricting the individual to a quiet area or unlocked quiet room.

Application of time out:

1. A resident in time out must never be physically prevented from leaving the time out area.
2. Time out may take place away from the area of activity or from other residents.
3. Staff must monitor the resident while he or she is in time out.

Section 7.2: Emergency safety intervention

An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age, size, gender, physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions must be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a resident from harming self or others by exerting external control over physical movement.

Physical restraint is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a resident's body. **Physical restraint should be used only as a last resort after all verbal de-escalation techniques have failed and when the resident is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the resident's body,

most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in YRC I residential facilities.**

Each facility must have a written restraint policy and all staff must be trained to provide safe physical restraints in the event of an emergency safety intervention. Staff must be trained in authorized, well-recognized training programs for managing aggressive behavior. Staff training records must be kept as part of the staff member's personnel file and must be made available upon request. At the time of admission to a facility, the resident and parent/guardian must be oriented to the restraint policies of the facility and must sign a written acknowledgment or this orientation. This written acknowledgment shall be kept in the client's case record.

Section 7.3: Reporting Abuse/Neglect

Physical Abuse means the infliction of physical harm on a child or the causation of a child's deterioration, or the likelihood of harm or deterioration. K.A.R. 30-46-10

Sexual Abuse means any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include allowing, permitting, or encouraging a child to engage in prostitution or to be photographed, filmed, or depicted in obscene or pornographic material. Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity, or coercion. K.A.R. 30-46-10

Mental or Emotional Abuse means the infliction of mental or emotional harm to a child or the causation of a child's deterioration. This term may include, but shall not be limited to, maltreatment or exploitation of a child to the extent the child's health is likely to be harmed.

This term may include the following:

1. terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;
2. emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child;
3. corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behaviors. K.A.R. 30-46-10

Neglect means any act or omission by a parent, guardian or person responsible for the care of a child resulting in harm to a child or presenting a likelihood of harm and the acts or omissions are not due solely to the lack of financial means of a child's parent or other custodian. Neglect may include but, shall not be limited to:

1. failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;
2. failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or the likelihood of harm to the child; or
3. failure to use resources available to treat a diagnosed medical condition if the treatment will make the child substantially more comfortable, reduce pain and suffering, correct or substantially diminish a crippling condition, or prevent the condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202(t)

Section 7.4: Mandated Reporters

Mandated reporters must report all witnessed or suspected abuse/neglect to SRS through the SRS Kansas

Abuse/Neglect Hotline.

K.S.A. 38-2223 states that when any of the following persons has reason to suspect that a child has been harmed as a result of physical, mental or emotional abuse or neglect or sexual abuse, the person shall report the matter promptly:

A. The following persons providing medical care or treatment: Persons licensed to practice the healing arts, dentistry and optometry; persons engaged in postgraduate training programs approved by the state board of healing arts; licensed professional or practical nurses; and chief administrative officers of medical care facilities;

B. The following persons licensed by the state to provide mental health services: Licensed psychologists, licensed masters level psychologists, licensed clinical psychotherapists, licensed social workers, licensed marriage and family therapists, licensed clinical marriage and family therapists, licensed professional counselors, licensed clinical professional counselors and registered alcohol and drug abuse counselors;

C. Teachers, school administrators or other employees of an educational institution which the child is attending and persons licensed by the secretary of health and environment to provide child care services or the employees of persons so licensed at the place where the child care services are being provided to the child; and

D. Firefighters, emergency medical services personnel, law enforcement officers, juvenile intake and assessment workers, court services officers and community corrections officers, case managers appointed under K.S.A. 23-1001 et seq., and amendments thereto, and mediators appointed under K.S.A. 23-602, and amendments thereto.

Abuse/neglect reported or witnessed in any YRC I must be immediately reported to the youth's custodial case manager and SRS through the SRS Kansas Abuse/Neglect Hotline (1-800-922-5330). The Abuse/Neglect Hotline number must be posted in a prominent place in the facility. Any employee of the facility who witnesses or hears about the abuse/neglect of a resident within that facility is to notify the Director of the facility immediately, except in cases where the alleged perpetrator is the facility Director. The facility Director is responsible to see to it that all cases of abuse/neglect are reported to them and are passed on to the resident's custodial case manager and SRS through the SRS Kansas Abuse/Neglect Hotline. At no time shall the administration of a program in which abuse/neglect has allegedly occurred interfere or otherwise attempt to alter the report of an abuse/neglect claim made by an employee of that facility.

Section 8: Critical Incidents

A Critical Incident is an occurrence that requires the provider to make a response that is not a part of the program's ordinary daily routine.

Section 8.1: Critical Incident Reporting

Critical incidents are to be reported to the youth's custodial case manager and the youth's parent or guardian when appropriate.

Each facility shall develop an internal process for obtaining on-call/emergency contact information for all custodial case managers in the event of an emergency or critical incident.

The following critical incidents should be verbally reported immediately with a written report to the custodial case manager within 24 hours of the event (please refer to the following definitions for

clarification):

- **Attempted suicide**: The attempt to intentionally kill oneself and the attempt caused injury or could have resulted in serious injury or death if not detected.
- **Suicide**: Intentionally killing oneself.
- **Homicide**: The killing of one person by another.
- **Other death**: Accidental death or death from natural causes of youth.
- **Assault/Battery**: Verbally creating fear of bodily harm and/or the causing bodily harm against another person.
- **Sexual misconduct**: Any sexual conduct between youth or between youth and staff/volunteers. Sexual conduct includes the intentional touching of another person's intimate parts, or the clothing covering the immediate area of the intimate parts, committed with sexual or aggressive intent.
- **Alleged maltreatment of youth**: Any act or situation of abuse and/or neglect, as defined by K.A.R. 30-46-10.
- **Serious youth injury/illness**: Any youth illness that requires the youth to be hospitalized or receive significant medical treatment. Significant medical treatment is treatment that could not be handled by a trained health care person outside of the hospital or clinical setting.
- **Serious infectious disease**: Diseases such as, but not limited to TB, Hepatitis A/B/C, or a serious sexually transmitted disease as tracked by the Center for Disease Control (CDC). This only needs to be reported if there is a threat of transmission of the disease to staff or other youth.
- **Riot/Hostage situation**: Any disturbance by three or more youth that seriously disturbs the operation of a facility, jeopardizes the control of an area, threatens violence against or destruction of property, or results in significant property damage or personal injury to youth or staff. Includes any hostage situation.
- **Natural disaster**: Acts of nature which cause personal injury to staff and/or youth or which causes structural damage to the physical structure housing youth.
- **AWOL**: A youth's departure from a placement or supervision without lawful authority, as defined by K.S.A. 75-712f. This also includes youth while on a supervised off grounds setting (i.e. transports, hospital, and medical visits). Reported verbally to law enforcement and the custodial case manager immediately with a written report to the custodial case manager within 24 hours of the event. An immediate verbal notification is to be made to law enforcement and to the custodial case manager when the youth returns or is located.
- **Other**: Any action or situation which would require a response by law enforcement, the fire department, an ambulance or another emergency response provider. Incidents in this category would also include any incident not reported in another category and have the potential for significant media coverage.

If the critical incident involves abuse or neglect, the facility must also follow mandated reporting requirements.

All facilities must have procedures for reporting critical incidents to administrative staff and recording critical incidents in the resident files. An administrative file of critical incidents must be kept by facility.

An administrative file shall be kept by the facility documenting critical incidents that is separate from the documentation in the youth's file.

Section 9: Staff In-Service Training

Youth care staff shall be provided with a minimum of 24 documented clock hours per year which include, but are not limited to, training in human sexuality, behavior management, discipline, health care, and techniques in the prevention and treatment of drug and alcohol abuse.

Section 10: Record Keeping Requirements for the Facility

The record keeping requirements of K.A.R. 28-4-272 shall be met by the facility.

Record Retention: Case records, including medical records, shall be maintained 6 years from the date of the youth's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

Health Records: Health Care records of residents must meet the requirements of K.A.R. 28-4-275.

Chart Documentation: A dated record of daily observations and significant occurrences involving each youth shall be maintained. The record shall include events, which may affect the well-being of the youth. The record shall be available for review. Each report shall include the date and time of occurrence, the staff member and/or youth involved, the nature of the incident and the circumstances surrounding it.

YOUTH RESIDENTIAL CENTER II STANDARDS

Section 1: General Program Description and Requirements

A Youth Residential Center (YRC II) facility is a 24-hour group home or residential facility that meets the requirements of K.A.R. 28-4-268-280. It is a non-secure residential service designed to provide an environment that will enhance the youth's ability to achieve a higher level of functioning while avoiding future placement in a more highly structured treatment facility.

Section 1.1: Services Provided in Youth Residential Center

The range of services to be delivered by the YRC II facility to meet the variety of individual needs of the residents shall be well defined. The General Program description approved by SRS Children and Family Services or JJA for each facility shall include but not be limited to the goals of the program, resident behavioral treatment system, job descriptions (responsibilities, functions, and qualifications), policies and procedures, daily living activities, health services, recreation activities, and visitation policies. The purpose of placement in an YRC II is to improve the youth's decision making, coping skills, social skills, and to address any underlying problems which are affecting the youth, while teaching the youth how to handle their behaviors in order to transition successfully back into their family or community.

Section 2: General Staffing Requirements

Twenty-four hour care which has been licensed by KDHE (K.A.R. 28-4-268-280) as a group home or residential center to cover the programming the facility will provide to the population of children/youth whom the facility will serve.

- The administrator in a YRC II shall have a Bachelors degree.
- Program plan development, review, and case supervision are carried out by the YRC II Provider. The youth to case coordinator ratio in a YRC II is 1:16. The Case Coordinator shall have at least a bachelor's degree in one of the human service fields (social work, psychology, human development and family life, criminal justice, counseling), nursing, or education. Facility staff must be trained to effectively meet the special needs of youth who require this level of care.
- Facility childcare staff shall be at least 21 years of age with a minimum of three years age difference between the childcare worker and oldest resident who can be admitted to the facility. Childcare staff must have completed 32 hours of in-service training provided by the facility before they can function independently.
- There shall be 24-hour awake staff to insure child safety.

Section 3: Criteria for the Youth's Admission

Population Served:

- Population served is children and youth, ages 6 thru 22, who:
  - Have a well established pattern of behavior or conduct which is antisocial, oppositional, defiant, aggressive, abusive, impulsive or high risk in nature.
  - YRC II facilities may also serve those children and youth in Police Protective Custody.
- Youth who DO NOT meet the standard for Psychiatric Residential Treatment Facility (PRTF) admission, who are not in need of intensive treatment, and for whom family based services are not appropriate to meet the youth's needs.
- Youth awaiting a PRTF screen may reside in a YRC II until the time of the screen.
- If a youth is in a YRC II awaiting a screen the screen must be completed within 14 days, but should be completed as soon as possible. If the youth screens into a PRTF they can stay up to 14 days while awaiting a PRTF bed.

- No more than 50 percent of the youth in a YRC II facility may have screened into a PRTF and be in the 14 day waiting period for a PRTF placement.
- Youth may step down to a YRC II from a PRTF after the screener and treatment team have determined the youth no longer needs the level of care provided by a PRTF.

Section 3.1: Placement Agreement

A Placement Agreement must be completed between the YRC II and the referring agency. A copy of the Placement Agreement must be kept in the youth's file at the facility.

The initial service authorization period for a YRC II stay will be for 90 days. Service extensions will be for a period of time not to exceed 60 days, and will be examined by the youth's custodial case manager to ensure the youth is receiving the services they need to reintegrate into the community. The youth may continue receiving services in the YRC II facility as long as they continue to require this level of care as determined by the youth's custodial case manager.

Section 4: Resident Lodging

In order to support the daily management and administration of residents, each residential provider shall develop an objective procedure regarding the physical housing of juvenile offenders. Youth placed in a residential setting shall be assigned to a room based upon various factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning rooms shall include (but are not limited to):

- Risk to recidivate (as determined by evidence-based risk assessments)
- Suicidal tendencies
- Level of specialized needs (i.e. mental health, medical, etc.)
- Sex offender status
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc.)
- Vulnerability to being victimized by others (i.e. physical stature)

While each youth will have an individualized program plan, assigning rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and effective management of the living units.

Section 5: Residential Care Program

Section 5.1: Residential Care System

Each YRC II shall have a written program of consistent rules and regulations guiding and governing the daily behavior of the youth under the care of the program. The behavior management system should include a description of daily general routines of the program. The system of rules, rewards, and consequences for given behaviors should be identified. Each youth shall be oriented to the YRC II's behavior management system by a staff member during the admission or orientation process. Notation shall be made in the youth's file and signed by the youth that the rules and regulations, rewards and consequences have been discussed with the youth.

The YRC II facility must post the behavior management system in a common area where youth are able to easily access the system and the youth should be given a written copy of the system to use as a reference. The system should include rules governing interpersonal interactions with staff and peers, facility leave policies, school attendance and behavior while at school, verbal and physical aggression,

allowable possessions, awakening and bedtime hours, leisure hours, visitation policies, AWOL attempts, involvement in recreation and other activities, self-destructive behaviors, sexuality, communications with family and others outside the program, religious worship, involvement in therapies, theft, property destruction, behaviors resulting in mandatory removal from the program, and behaviors at the program which could result in legal prosecution.

The overarching goals should be to not only help the youth adjust to the residential facility but also to daily life within society.

Section 5.2: Education Requirement

All facilities shall have an education agreement with a school district certified by the state board of education. The facility shall ensure routine communications between the staff and any educational program in which the youth is placed. This may include requesting and participating in the development of an Individual Education Plan for each resident when appropriate. These contacts shall be noted in the youth's case record.

Section 5.3: Scope of Services

The provider shall write a policy and procedure manual for the operation of the YRC II facility that will be reviewed and approved by SRS Children and Family Services and the Juvenile Justice Authority. It will provide a program for youth in the facility that covers the following program components:

Daily Living Services - Daily living services shall be provided and include the following:

- Room, board, child care, personal spending money, and school fees.
- Transportation to appointments within a 60-mile radius; including to and from school, medical care, recreation, etc.
- Academic activities - assistance with school work, vocational training, and/or G.E.D. training.

Situational Training- to include but not limited to:

- Personal Hygiene – Teaching about body cleanliness, use of deodorants and cosmetics, appropriate clothing, choosing clothing to fit individual and occasion, and keeping clothes neat and clean.
- Health - Identifying and understanding residents' health needs; securing and utilizing necessary medical treatment including preventive and health maintenance services; gaining information and education in health maintenance (including preventive measures, nutrition, menstruation, rest, cleanliness, family planning, drugs, sexually transmitted diseases, exercise, and motivation for meeting own health needs), maintaining contact with providers of health services (physician, nurse, clinic) and using outside resources for assistance (clinics, pharmacies, hospitals).
- Consumer education for independent living- Budgeting, comparative buying, installment buying, avoiding risks, identifying illegal or excessive interest rates, use of credit, avoiding or dealing with debts, using checking and savings accounts, and paying taxes.

Communication skills:

The youth's articulating thoughts and feelings through appropriate use of such skills as speech, writing, and use of the telephone.

Home Management:

Making the bed and changing linens, using the vacuum cleaner, dusting, organizing belongings, disposing of trash, cleaning all areas of the home, operating appliances, cooking complete meals, making simple

repairs, who to call when a major repair is needed, being aware of the need for upkeep, handling emergencies, knowing first aid.

Situational Guidance:

Identifying and accepting strengths, developing patterns of acceptance and coping with authority figures, getting along with others, sharing responsibility, being considerate of others, developing friendships, knowing when to go home when visiting, recognizing or modifying attitudes toward self or others, responsible work attitudes, tolerance of verbal criticism, reactions to praise, punctuality, and attendance.

Recreation:

Participating in leisure time activities, learning how to spend leisure time, developing outside activities, managing time, finding recreation with little or no expense involved, finding community projects to take part in, participating in social groups, participating in sports and games, arts and crafts, and appreciating fine arts.

The daily schedule shall address the needs of the residents and the use of time to enhance the resident's physical, mental, emotional, and social development. The facility shall provide supervised indoor and outdoor recreation so that every resident may participate. Age appropriate equipment to promote physical development and physical fitness shall be available. Age appropriate socialization shall be provided utilizing community resources to assist the youth in transitioning back into their community when appropriate.

Section 5.4: Initial Assessment

When a youth enters the facility, the YRC II shall begin assessing their strengths and needs within twenty-four (24) hours and shall have a completed assessment within 7 days. The assessment shall include but not be limited to the following:

- Reasons for referral to the facility
- Evaluation or assessment covering the following areas:
    1. physical health
    2. family relations
    3. academic or vocational training
    4. community life
    5. interpersonal interactions
    6. daily living skills as outlined in the scope of services listed above
    7. immediate service needs.

Section 5.5: Accessing Outpatient Mental Health/Substance Use Disorder Services

Only Outpatient Mental Health/Substance Use Disorder services are allowed while a youth is residing in an out of home placement (excluding PRTF placement). If outpatient services are needed, the provider shall coordinate assessments and services through SRS behavioral health managed care program associates of the Prepaid Ambulatory Health Plan (PAHP) and/or of the Prepaid Inpatient Health Plan (PIHP). The PAHP and PIHP associates will determine the type, frequency and duration of services required to meet the individualized Mental Health/Substance Use Disorder needs of each youth.

Upon admission or during the course of the youth's stay, if the youth begins to exhibit behavior/needs which cannot be addressed by the placement or through outpatient services, the provider shall collaborate with the custodial case manager to obtain an appropriate screen/assessment to determine the level of services required.

If the youth is receiving Mental Health/Substance Use Disorder services from a PAHP or PIHP associate, including a community mental health center or independent practitioner, at the time of admission, the youth may continue services by the same provider to maintain continuity of service.

Providers may employ, contract or otherwise partner with associates of the PAHP and/or PIHP to provide Outpatient Mental Health/Substance Use Disorder services to youth residing at the program.

Providers shall not prohibit the youth's ability to request or receive services from any willing provider who are authorized associates of the PAHP or PIHP.

Section 5.6: Program Plan

Each youth residing in a residential facility must have a program plan that is based on a thorough assessment. Assessment documents must be included in the case record. The program plan shall be established by the end of 14 days from admission and shall address the identified needs in the emotional, physical, educational, social, familial, and where appropriate independent living skill domains. Youth may not have identified needs in every domain. If so, note that no needs were identified. Program plans should be updated when new needs are identified or when program goals are met. Program plans should be thoroughly reviewed and revisions made at the case review conferences within 30 days of admission and each 30 days thereafter. Information obtained from the youth, parent, guardian, and custodial case manger shall be considered in the report.

The program plan shall include individualized services to match the youth's identified needs in the following areas:

- Long term goals in the areas of physical health, family relations, daily living skills, academic and/or vocational skills, interpersonal relations, and emotional/psychological health.
- Short term goals which will help a youth eventually reach his/her long term goals in each of the above areas.
- Services to meet independent living goals.
- Specific plans for reaching the short-term goals including services to be provided and frequency.
- Estimated time for reaching short term goals.
- The youth's signature on the plan indicating that the youth has participated in the development of the program plan.

Section 5.7: Discharge/Aftercare Plan

Discharge planning shall begin upon admission of the youth to the facility. At a minimum, the resident, the resident's parents or guardian, and the placing agency should be involved in planning the discharge of a resident from the facility. The discharge plan and modifications to it should be noted in the case file.

A discharge summary shall be completed at the time of the youth's discharge. This shall include delineation of after-care plans and goals which the youth have reached. Written recommendations for aftercare shall be made and should specify the nature, frequency, and duration or services the facility recommends for the youth. The plan shall also document who the responsible parties are for aftercare services.

Section 5.8: Case Coordination

The YRC II's case coordinator has the responsibility for coordinating the youth's program and progress with school, employer, family, and other appropriate community resources. The Case Coordinator will maintain a resource base of services to address the needs identified in Individual Program Plans.

Section 5.9: Home Visits

When home visits are a part of the program plan, there shall be pre and post home visit contacts between the youth, their family, and facility program staff regarding the home visit including written pre and post documentation on the home visit. Because the goal of placement is to return the youth to a family-like setting, it is important that home visits be carefully planned and executed in the best interests of permanency planning for the youth. All home visits shall be arranged through coordination with the child's custodial case manager.

Section 6: Resident's Rights

The staff of the facility shall allow privacy for each youth. The facility's space and furnishings shall be designed and planned with respect for the resident's right to privacy. The facility's design shall also provide supervision according to the ages and needs of the residents. Each resident shall have a quiet area where they can withdraw from the group when appropriate.

Contacts between the resident and their parents/guardian shall be allowed while the resident is in care unless the rights of the parents have been terminated by court order or family contact is not in the resident's best interest. The frequency of contact shall be determined by the needs of the resident and his/her family or guardians per program plan requirements.

The facility shall have clearly written policies regarding visits, gifts, mail, E-mail and telephone (including cell phone) calls between the resident and their family, or guardian. These policies shall be made known to the resident and his/her family/guardian at or prior to admission.

Residents shall be allowed to send and receive mail and have telephone conversations with family members/guardians unless it is not in the best interest of the youth, the safety and security of facility, or if a court order necessitates restrictions.

If restrictions on communications or visits are necessary these shall be documented in the youths program plan and reviewed at the 30-day case reviews. The youth's custodial case manager must be notified of any new restrictions to communications or visitation implemented by the facility prior to its implementation.

A resident shall be allowed to bring personal possessions to the facility and may acquire other possessions in accordance with the policies of the facility. Prior to admission, information shall be made available to the youth and their parents/guardians concerning what possessions a youth may bring to the facility and the kinds of gifts they may receive. Possessions, which a youth cannot have or receive at the facility, shall be specified in writing and distributed to the youth and their parents/guardians.

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Section 7: Special Circumstances Affecting Youth in Residential Placement

Section 7.1: Time Out

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Application of time out:

1. A resident in time out must never be physically prevented from leaving the time out area.
2. Time out may take place away from the area of activity or from other residents.
3. Staff must monitor the resident while he or she is in time out.

Section 7.2: Emergency safety intervention

An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age, size, gender physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions must be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a resident from harming self or others by exerting external control over physical movement.

Physical restraint is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a resident's body. **Physical restraint should be used only as last resort after all verbal de-escalation techniques have failed and when the resident is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the resident's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in YRC II residential facilities.**

Each facility must have a written restraint policy and all staff must be trained to provide safe physical restraints in the event of an emergency safety intervention. Staff must be trained in authorized, well-recognized training programs for managing aggressive behavior. Staff training records must be kept as part of the staff member's personnel file and must be made available upon request. At the time of admission to a facility, the resident and parent/guardian must be oriented to the restraint policies of the facility and must sign a written acknowledgment or this orientation. This written acknowledgment shall be kept in the client's case record.

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This term may include the following:

1. terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;
2. emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child;

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Neglect means any act or omission by a parent, guardian or person responsible for the care of a child resulting in harm to a child or presenting a likelihood of harm and the acts or omissions are not due solely to the lack of financial means of a child's parent or other custodian. Neglect may include but, shall not be limited to:

1. failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;
2. failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or the likelihood of harm to the child; or
3. failure to use resources available to treat a diagnosed medical condition if the treatment will make the child substantially more comfortable, reduce pain and suffering, correct or substantially diminish a crippling condition, or prevent the condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202(t)

Section 7.4: Mandated Reporters

Mandated reporters must report all witnessed or suspected abuse/neglect to SRS through the SRS Kansas Abuse/Neglect Hotline.

K.S.A. 38-2223 states that when any of the following persons has reason to suspect that a child has been harmed as a result of physical, mental or emotional abuse or neglect or sexual abuse, the person shall report the matter promptly:

A. The following persons providing medical care or treatment: Persons licensed to practice the healing arts, dentistry and optometry; persons engaged in postgraduate training programs approved by the state board of healing arts; licensed professional or practical nurses; and chief administrative officers of medical care facilities;

B. the following persons licensed by the state to provide mental health services: Licensed psychologists, licensed masters level psychologists, licensed clinical psychotherapists, licensed social workers, licensed marriage and family therapists, licensed clinical marriage and family therapists, licensed professional counselors, licensed clinical professional counselors and registered alcohol and drug abuse counselors;

C. teachers, school administrators or other employees of an educational institution which the child is attending and persons licensed by the secretary of health and environment to provide child care services or the employees of persons so licensed at the place where the child care services are being provided to the child; and

D. firefighters, emergency medical services personnel, law enforcement officers, juvenile intake and assessment workers, court services officers and community corrections officers, case managers appointed under K.S.A. 23-1001 et seq., and amendments thereto, and mediators appointed under K.S.A. 23-602, and amendments thereto.

Abuse/neglect reported or witnessed in any YRC II must be immediately reported to the youth's custodial case manager and SRS through the SRS Kansas Abuse/Neglect Hotline (1-800-922-5330). The Abuse/Neglect Hotline number must be posted in a prominent place in the facility. Any employee of the facility who witnesses or hears about the abuse/neglect of a resident within that facility is to notify the Director of the facility immediately, except in cases where the alleged perpetrator is the facility Director.

The facility Director is responsible to see to it that all cases of abuse/neglect are reported to them and are passed on to the resident's custodial case manager and or SRS through the SRS Kansas Abuse/Neglect Hotline. At no time shall the administration of a program in which abuse/neglect has allegedly occurred interfere or otherwise attempt to alter the report of an abuse/neglect claim made by an employee of that facility.

Section 8: Critical Incident

A Critical Incident is an occurrence that requires the provider to make a response that is not a part of the program's ordinary daily routine.

Section 8.1: Critical Incident Reporting

Critical incidents are to be reported to the youth's custodial case manager and the youth's parent or guardian when appropriate.

"Each facility shall develop an internal process for obtaining on-call/emergency contact information for all custodial case managers in the event of an emergency or critical incident."

The following critical incidents should be verbally reported immediately with a written report to the custodial case manager within 24 hours of the event (please refer to the following definitions for clarification):

- **Attempted suicide**: The attempt to intentionally kill oneself and the attempt caused injury or could have resulted in serious injury or death if not detected.
- **Suicide**: Intentionally killing oneself.
- **Homicide**: The killing of one person by another.
- **Other death**: Accidental death or death from natural causes of youth.
- **Assault/Battery**: Verbally creating fear of bodily harm and/or the causing bodily harm against another person.
- **Sexual misconduct**: Any sexual conduct between youth or between youth and staff/volunteers. Sexual conduct includes the intentional touching of another person's intimate parts, or the clothing covering the immediate area of the intimate parts, committed with sexual or aggressive intent.
- **Alleged maltreatment of youth**: Any act or situation of abuse and/or neglect, as defined by K.A.R. 30-46-10.
- **Serious youth injury/illness**: Any youth illness that requires the youth to be hospitalized or receive significant medical treatment. Significant medical treatment is treatment that could not be handled by a trained health care person outside of the hospital or clinical setting.
- **Serious infectious disease**: Diseases such as, but not limited to TB, Hepatitis A/B/C, or a serious sexually transmitted disease as tracked by the Center for Disease Control (CDC). This only needs to be reported if there is a threat of transmission of the disease to staff or other youth.
- **Riot/Hostage situation**: Any disturbance by three or more youth that seriously disturbs the operation of a facility, jeopardizes the control of an area, threatens violence against or destruction of property, or results in significant property damage or personal injury to youth or staff. Includes any hostage situation.
- **Natural disaster**: Acts of nature which cause personal injury to staff and/or youth or which causes structural damage to the physical structure housing youth.
- **AWOL**: A youth's departure from a placement or supervision without lawful authority, as defined by K.S.A. 75-712f. This also includes youth while on a supervised off grounds setting (i.e. transports, hospital, and medical visits). Reported verbally to law enforcement and the custodial case manager immediately with a written report to the custodial case manager within 24

hours of the event. An immediate verbal notification is to be made to law enforcement and to the custodial case manager when the youth returns or is located.

- **Other**: Any action or situation which would require a response by law enforcement, the fire department, an ambulance or another emergency response provider. Incidents in this category would also include any incident not reported in another category and have the potential for significant media coverage.

If the critical incident involves abuse or neglect, the facility must also follow mandated reporting requirements.

All facilities must have procedures for reporting critical incidents to administrative staff and recording critical incidents in the resident files. An administrative file of critical incidents must be kept by facility.

An administrative file shall be kept by the facility documenting critical incidents that is separate from the documentation in the youth's file.

Section 9: Staff In-Service Training

Each facility must have an in-service orientation/training program for new employees, which is especially directed toward the initial training needs of staff working directly with residents. Documentation of completion of orientation training must be kept in the staff member's personnel file. The in-service orientation program shall provide written documentation that all staff are oriented to the following:

A. Facility policy and procedures manual
B. Facility emergency and evacuation procedures
C. Emergency safety interventions (including management of aggressive or suicidal behavior and orientation to the facility's restraint policies and procedures)
D. The handling of blood borne pathogens
E. Facility discipline standards
F. Abuse/neglect mandatory reporting laws
G. Client record documentation policies and procedures
H. Policies and procedures for resident medication management
I. Resident rights
J. Confidentiality laws
K. Training in CPR/First Aid within 3 months of employment
L. De-escalation techniques

Each facility shall also have a written annual staff in-service training plan which addresses the annual training needs of all staff having direct contact with residents. This annual training is beyond or in addition to the initial 32-hour orientation training program. All YRC II direct care staff shall have a minimum of forty (40) documented clock hours of in-service training per year. Documentation shall be provided in each staff member's personnel record to include content, amount of time, trainer, and his/her qualifications. Topics shall include but not be limited to:

A. CPR and First Aid
B. Blood borne pathogens
C. Medications
D. Emergency safety interventions
E. Substance use disorder patterns
F. Childhood and adolescent development (including developmental disorders)
G. Childhood and adolescent psycho-pathology (including such topics as effects of abuse/neglect, reactive attachment disorders, separation anxiety disorders, ADHD)
H. Childhood and adolescent sexuality issues, especially the effects of early sexual abuse

I. De-escalation techniques

Section 10: Record Keeping Requirements for the Facility

The record keeping requirements of K.A.R. 28-4-272 shall be met by the facility. In addition, the following shall be kept by the facility.

Record Retention: Case records, including medical records, shall be maintained for 6 years from the date of the youth's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

Chart Documentation: A dated record of daily observations and significant occurrences involving each youth shall be maintained. The record shall include events, which may affect the well-being of the youth. The record shall be available for review. Each report shall include the date and time of occurrence, the staff member and/or youth involved, the nature of the incident and the circumstances surrounding it.

Weekly Progress Notes: Notes shall be completed by the case coordinator and staff providing services. These notes must be entered into the youth's chart, reflecting the delivery of services according to the program plan. This documentation must address the youth's responses to interventions and the progress of the youth on individualized goals and objectives. The note should include any significant events that occurred during the week and should also summarize contacts with family members and other involved agencies. If any unmet needs are identified, the note must reflect the actions to be taken to revise the plan for the youth to meet that need.

Health Records: Health Care and Records of residents must meet the requirements of K.A.R. 28-4-275.

Progress Reports: Thirty-day progress reports shall document progress on specific short-term goals, describe significant revisions in goals and strategies, and specify any new program goals and strategies during the period covered. The 30-day progress reports shall summarize progress and note changes regarding long-term placement and program goals and shall be provided to the referring agency.

Permanency Planning: Includes the evaluation and design of an approach for the youth and family that focuses on opportunities for the youth to have ongoing active and meaningful connections with family, kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the youth's custodial case manager and be included in the program plan to be reviewed every 30 days. The permanency plan shall include strategies and tasks to accomplish the youth's goals. Behaviors which place the youth at risk for disruption, activities to prepare the youth's family or kinship network for reunification, identification of other less restrictive living environments and preparing the youth for transition to these settings shall be addressed.

EMERGENCY SHELTER STANDARDS

Section 1: General Program Description and Requirements

An Emergency Shelter provides twenty-four hour care that meets the requirements of K.A.R. 28-4-268-280. It has been licensed by KDHE as a Group Boarding Home or Residential Center to cover the programming the facility will provide for the populations of children/youth whom the facility will serve.

Section 1.1: Services Provided in an Emergency Shelter

The purpose of placement in an Emergency Shelter is to ensure the youth has a short-term safe place to stay until a long-term placement for the youth can be found.

The range of services to be delivered by the Emergency Shelter shall be documented in the facilities program description. The general program description approved by SRS Children and Family Services and/or JJA for each facility shall include but not be limited to the goals of the program, resident behavioral treatment system, job descriptions (responsibilities, functions, and qualifications), policies and procedures, daily living activities, health services, recreation activities, and visitation policies.

Section 1.2: Short Term Placement in an Emergency Shelter

Youth shall not be placed in an emergency shelter for more than 30 days unless an extension is approved for a circumstance as indicated below:

- Extensions may only be requested by the referring agency. Extension requests for youth in JJA custody are made by the community supervision officer to JJA central office. Extension requests and decisions for youth in SRS custody are managed by the child welfare case management provider.
- Extensions to the 30 day emergency shelter stay will only be considered in the following circumstances:
    - If a youth is placed in an Emergency Shelter in the same school district from which they were previously attending and no alternative placement is available in the district. If the youth will be finishing the school term within 60 days of admission to the Emergency Shelter and movement of the youth would result in the loss of school credit.
    - The youth is awaiting an identified placement, which will be available within 45 days of admission to the Emergency Shelter.
    - A circumstance of substantially the same nature as above and the referring agency feels it is in the best interest of the child or youth to request an extension.

Section 2: General Staffing Requirements

Twenty-four hour care which has been licensed by KDHE (K.A.R. 28-4-268-280) as a group boarding home or residential center to cover the programming the facility will provide to the population of children/youth whom the facility will serve.

- The administrator of a residential center shall have a Bachelor's degree, prior administrative experience and a working knowledge of child development principles.
- The administrator of a group boarding home shall have at least a high school diploma, or its equivalent, prior administrative experience and a working knowledge of child development principles.
- Program plan development, review, and case supervision are carried out by the Emergency Shelter provider.
- Child care staff shall be at least 21 years of age, have at least a high school diploma or equalivent and shall practice accepted methods of child care. Staff must be trained to effectively meet the

special needs of youth who require this level of care and must have completed 24 hours of in-service training provided by the facility before they can function independently.
- The facility must be staffed appropriately to meet the needs of all the residents in their care. The staff ratio is 1:7 during waking hours and 1:10 during sleeping hours. To insure child safety, the Emergency Shelter facility will have awake staff 24 hours a day.

Section 3: Criteria for the Youth's Admission

Population Served:

Population served is children and youth, ages birth thru 22, who:
- Need safety and a short term placement until a more appropriate stable placement can be found for the child/youth.
- Emergency Shelter facilities may also serve those children and youth in Police Protective Custody.

Emergency Shelters are unique in their ability to accept youth who present a wide range of behavioral and health needs. Emergency Shelter's must also be uniquely trained to deal with youth in trauma. Emergency Shelters are staffed and administered to serve all youth from the state agencies with whom they have Provider Agreements and who arrive at their door for services. Placements of youth should only be denied in the most extreme circumstances, when the youth's safety or the safety of other residents in the Emergency Shelter cannot be assured.

Section 3.1: Placement Agreement

A Placement Agreement must be completed between the provider and the referring agency. A copy of the Placement Agreement must be kept in the youth's file at the facility.

Section 4: Resident Lodging

In order to support the daily management and administration of residents, each residential provider shall develop an objective procedure regarding the physical housing of juvenile offenders. Youth placed in a residential setting shall be assigned to a room based upon various factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning rooms shall include (but are not limited to):

- Risk to recidivate (as determined by evidence-based risk assessments)
- Suicidal tendencies
- Level of specialized needs (i.e. mental health, medical, etc.)
- Sex offender status
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc.)
- Vulnerability to being victimized by others (i.e. physical stature)

While each youth will have an individualized program plan, assigning rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and effective management of the living units.

Section 5: Residential Care Program

Section 5.1: Residential Care System

Emergency Shelter's shall have a written program of consistent rules and regulations guiding and governing the daily behavior of the youth under the care of the program. The behavior management system should include a description of daily general routines of the program. The system of rules, rewards, and consequences for given behaviors should be identified. The overarching goals should be to not only help the youth adjust to the residential facility but also to daily life within society.

Each youth shall be oriented to the Emergency Shelter's behavior management system by a staff member during the admission or orientation process. The Emergency Shelter facility should also post the behavior management system in a common area where youth are able to easily access the system or the youth should be given a written copy of the system to use as a reference. The system should include rules governing interpersonal interactions with staff and peers, facility leave policies, school attendance and behavior while at school, verbal and physical aggression, allowable possessions, awakening and bedtime hours, leisure hours, visitation policies, AWOL attempts, involvement in recreation and other activities, self-destructive behaviors, sexuality, communications with family and others outside the program, religious worship, involvement in therapies, theft, property destruction, behaviors resulting in mandatory removal from the program, and behaviors at the program which could result in legal prosecution.

Section 5.2: Education Requirement

All facilities shall have an education agreement with a school district certified by the state board of education. The facility shall ensure routine communications between the staff and any educational program in which the youth is placed. This may include requesting and participating in the development of an Individual Education Plan for each resident when appropriate. These contacts shall be noted in the youth's case record.

Section 5.3: Scope of Services

The provider shall write a policy and procedure manual for the operation of the Emergency Shelter facility that will be reviewed and approved by SRS Children and Family Services and the Juvenile Justice Authority. It will provide a program for youth in the facility that covers the following program components:

Daily Living Services - Daily living services shall be provided and include the following:

- Room, board, child care, personal spending money, and school fees.
- Transportation to appointments within a 60-mile radius; including to and from school, medical care, recreation, etc.
- Academic activities - assistance with schoolwork, vocational training, and/or G.E.D. training.

Situational Training- to include but not limited to:

- Personal Hygiene - Teaching about body cleanliness, use of deodorants and cosmetics, appropriate clothing, choosing clothing to fit individual and occasion, and keeping clothes neat and clean.
- Health - Identifying and understanding residents' health needs; securing and utilizing necessary medical treatment including preventive and health maintenance services; gaining information and education in health maintenance (including preventive measures, nutrition, menstruation, rest, cleanliness, family planning, drugs, sexually transmitted diseases, exercise, and motivation for meeting own health needs), maintaining contact with providers of health services (physician, nurse, clinic) and using outside resources for assistance (clinics, pharmacies, hospitals).

- Consumer education for independent living- Budgeting, comparative buying, installment buying, avoiding risks, identifying illegal or excessive interest rates, use of credit, avoiding or dealing with debts, using checking and savings accounts, and paying taxes.

Communication skills:

The youth's articulating thoughts and feelings through appropriate use of such skills as speech, writing, and use of the telephone.

Home Management:

Making the bed and changing linens, using the vacuum cleaner, dusting, organizing belongings, disposing of trash, cleaning all areas of the home, operating appliances, cooking complete meals, making simple repairs, who to call when a major repair is needed, being aware of the need for upkeep, handling emergencies, knowing first aid.

Situational Guidance:

Identifying and accepting strengths, developing patterns of acceptance and coping with authority figures, getting along with others, sharing responsibility, being considerate of others, developing friendships, knowing when to go home when visiting, recognizing or modifying attitudes toward self or others, responsible work attitudes, tolerance of verbal criticism, reactions to praise, punctuality, and attendance.

Recreation:

Participating in leisure time activities, learning how to spend leisure time, developing outside activities, managing time, finding recreation with little or no expense involved, finding community projects to take part in, participating in social groups, participating in sports and games, arts and crafts, and appreciating fine arts.

The daily schedule shall address the needs of the residents and the use of time to enhance the resident's physical, mental, emotional, and social development. The facility shall provide supervised indoor and outdoor recreation so that every resident may participate. Age appropriate equipment to promote physical development and physical fitness shall be available. Age appropriate socialization shall be provided utilizing community resources to assist the youth in transitioning back into their community when appropriate.

Section 5.4: Initial Assessment

When a child or youth enters the facility, staff will immediately begin assessment including documentation. The assessment shall include but not be limited to the following considerations and/or tasks:

1. Reasons for referral to the facility
2. Family relations
3. Academic or vocational training
4. Community life
5. Interpersonal interactions
6. Daily living skills
7. Immediate treatment needs
8. Physical health
9. Placement needs of the youth must be assessed with regard to most appropriate next placement
10. Involvement or exposure to substance use disorders
11. Involvement or exposure to other trauma

12. Assessment of youth's self-injuring or suicidal attempts

Section 5.5: Accessing Outpatient Mental Health/Substance Use Disorder Services

Only Outpatient Mental Health/Substance Use Disorder services are allowed while a youth is residing in an out of home placement (excluding PRTF placement). If outpatient services are needed, the provider shall coordinate assessments and services through SRS behavioral health managed care program associates of the Prepaid Ambulatory Health Plan (PAHP) and/or of the Prepaid Inpatient Health Plan (PIHP). The PAHP and PIHP associates will determine the type, frequency and duration of services required to meet the individualized Mental Health/Substance Use Disorder needs of each youth.

Upon admission or during the course of the youth's stay, if the youth begins to exhibit behavior/needs which cannot be addressed by the placement or through outpatient services, the provider shall collaborate with the custodial case manager to obtain an appropriate screen/assessment to determine the level of services required.

If the youth is receiving Mental Health/Substance Use Disorder services from a PAHP or PIHP associate, including a community mental health center or independent practitioner, at the time of admission, the youth may continue services by the same provider to maintain continuity of service.

Providers may employ, contract or otherwise partner with associates of the PAHP and/or PIHP to provide Outpatient Mental Health/Substance Use Disorder services to youth residing at the program.

Providers shall not prohibit the youth's ability to request or receive services from any willing provider who are authorized associates of the PAHP or PIHP.

Section 5.6: Program Plan

Program plan development, review, and case supervision are carried out by the Emergency Shelter provider. Progress reports shall be completed every 14 days from admission.

The program plan shall include:

- Short-term goals that will help a youth eventually reach stability in the next placement
- Specific plans for reaching the short-term goals including services to be provided and frequency
- Estimated time for reaching short-term goals
- The youth's signature and signature of all participants indicating that they have participated in the development of the program plan

Section 5.7: Discharge/Aftercare Plan

Discharge planning shall begin upon admission of the youth to the facility. At a minimum, the resident, the resident's parents or guardian, and the placing agency should be involved in planning the discharge of a resident from the facility. A discharge summary shall be completed at the time of the youth's discharge and forwarded to the case management agency.

Section 5.8: Case Coordination

Case Coordination and case supervision are carried out by the Emergency Shelter provider.

Section 5.9: Home Visits

When home visits are a part of the program plan, there shall be pre and post home visit contacts between

the youth, their family, and facility program staff regarding the home visit including pre and post written documentation on the home visit. Because the goal of placement is to return the youth to a family-like setting, it is important that home visits be carefully planned and executed in the best interests of permanency planning for the youth. All home visits shall be arranged through coordination with the child's custodial case manager.

Section 6: Resident's Rights

The staff of the facility shall allow privacy for each youth. The facility's space and furnishings shall be designed and planned with respect for the resident's right to privacy. The facility's design shall also provide supervision according to the ages and needs of the residents. Each resident shall have a quiet area where they can withdraw from the group when appropriate.

Contacts between the resident and their parents/guardian shall be allowed while the resident is in care unless the rights of the parents have been terminated by court order or family contact is not in the resident's best interest. The frequency of contact shall be determined by the needs of the resident and his/her family or guardians per program plan requirements.

The facility shall have clearly written policies regarding visits, gifts, mail, E-mail and telephone (including cell phone) calls between the resident and their family, or guardian. These policies shall be made known to the resident and his/her family/guardian at or prior to admission. Residents shall be allowed to send and receive mail and have telephone conversations with family members/guardians unless it is not in the best interest of the youth, the safety and security of facility, or if a court order necessitates restrictions.

If restrictions on communications or visits are necessary these shall be documented in the youths file. The youth's custodial case manager must be notified of any new restrictions to communications or visitation implemented by the facility prior to its implementation.

A resident shall be allowed to bring personal possessions to the facility and may acquire other possessions in accordance with the policies of the facility. Prior to admission, information shall be made available to the youth and their parents/guardians concerning what possessions a youth may bring to the facility and the kinds of gifts they may receive. Possessions, which a youth cannot have or receive at the facility, shall be specified in writing and distributed to the youth and their parents/guardians.

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Youth shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Youth shall not be subjected to remarks that belittle or ridicule them or their families. Residents shall not be denied food, mail, or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. Only staff members shall discipline residents.

Section 7: Special Circumstances Affecting youth in Emergency Shelter Placement

Section 7.1: Time Out

A procedure used to assist the individual to regain emotional control by removing the individual from his or her immediate environment and restricting the individual to a quiet area or unlocked quiet room.

Application of time out:

1. A resident in time out must never be physically prevented from leaving the time out area.
2. Time out may take place away from the area of activity or from other residents.
3. Staff must monitor the resident while he or she is in time out.

Section 7.2: Emergency safety intervention

An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age, size, gender, physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions must be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a resident from harming self or others by exerting external control over physical movement.

Physical restraint is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a resident's body. **Physical restraint should be used only as a last resort after all verbal de-escalation techniques have failed and when the resident is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the resident's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in Emergency Shelter residential facilities.**

Each facility must have a written restraint policy and all staff must be trained to provide safe physical restraints in the event of an emergency safety intervention. Staff must be trained in authorized, well-recognized training programs for managing aggressive behavior. Staff training records must be kept as part of the staff member's personnel file and must be made available upon request. At the time of admission to a facility, the resident and parent/guardian must be oriented to the restraint policies of the facility and must sign a written acknowledgment or this orientation. This written acknowledgment shall be kept in the client's case record.

Section 7.3: Reporting Abuse/Neglect

Physical Abuse means the infliction of physical harm on a child or the causation of a child's deterioration, or the likelihood of harm or deterioration. K.A.R. 30-46-10

Sexual Abuse means any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include allowing, permitting, or encouraging a child to engage in prostitution or to be photographed, filmed, or depicted in obscene or pornographic material. Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity, or coercion. K.A.R. 30-46-10

Mental or Emotional Abuse means the infliction of mental or emotional harm to a child or the causation of a child's deterioration. This term may include, but shall not be limited to, maltreatment or exploitation of a child to the extent the child's health is likely to be harmed.

This term may include the following:

1. terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;
2. emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child;
3. corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behaviors. K.A.R. 30-46-10

Neglect means any act or omission by a parent, guardian or person responsible for the care of a child resulting in harm to a child or presenting a likelihood of harm and the acts or omissions are not due solely to the lack of financial means of a child's parent or other custodian. Neglect may include but, shall not be

limited to:

1. failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;
2. failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or the likelihood of harm to the child; or
3. failure to use resources available to treat a diagnosed medical condition if the treatment will make the child substantially more comfortable, reduce pain and suffering, correct or substantially diminish a crippling condition, or prevent the condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202(t)

Section 7.4: Mandated Reporters

Mandated reporters must report all witnessed or suspected abuse/neglect to SRS through the SRS Kansas Abuse/Neglect Hotline.

K.S.A. 38-2223 states that when any of the following persons has reason to suspect that a child has been harmed as a result of physical, mental or emotional abuse or neglect or sexual abuse, the person shall report the matter promptly:

A. The following persons providing medical care or treatment: Persons licensed to practice the healing arts, dentistry and optometry; persons engaged in postgraduate training programs approved by the state board of healing arts; licensed professional or practical nurses; and chief administrative officers of medical care facilities;

B. The following persons licensed by the state to provide mental health services: Licensed psychologists, licensed masters level psychologists, licensed clinical psychotherapists, licensed social workers, licensed marriage and family therapists, licensed clinical marriage and family therapists, licensed professional counselors, licensed clinical professional counselors and registered alcohol and drug abuse counselors;

C. Teachers, school administrators or other employees of an educational institution which the child is attending and persons licensed by the secretary of health and environment to provide child care services or the employees of persons so licensed at the place where the child care services are being provided to the child; and

D. Firefighters, emergency medical services personnel, law enforcement officers, juvenile intake and assessment workers, court services officers and community corrections officers, case managers appointed under K.S.A. 23-1001 et seq., and amendments thereto, and mediators appointed under K.S.A. 23-602, and amendments thereto.

Abuse/neglect reported or witnessed in any Emergency Shelter must be immediately reported to the youth's custodial case manager and SRS through the SRS Kansas Abuse/Neglect Hotline (1-800-922-5330). The Abuse/Neglect Hotline number must be posted in a prominent place in the facility. Any employee of the facility who witnesses or hears about the abuse/neglect of a resident within that facility is to notify the Director of the facility immediately, except in cases where the alleged perpetrator is the facility Director. The facility Director is responsible to see to it that all cases of abuse/neglect are reported to them and are passed on to the resident's custodial case manager and SRS through the SRS Kansas Abuse/Neglect Hotline. At no time shall the administration of a program in which abuse/neglect has allegedly occurred interfere or otherwise attempt to alter the report of an abuse/neglect claim made by an employee of that facility.

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- **Suicide**: Intentionally killing oneself.
- **Homicide**: The killing of one person by another.
- **Other death**: Accidental death or death from natural causes of youth.
- **Assault/Battery**: Verbally creating fear of bodily harm and/or the causing bodily harm against another person.
- **Sexual misconduct**: Any sexual conduct between youth or between youth and staff/volunteers. Sexual conduct includes the intentional touching of another person's intimate parts, or the clothing covering the immediate area of the intimate parts, committed with sexual or aggressive intent.
- **Alleged maltreatment of youth**: Any act or situation of abuse and/or neglect, as defined by K.A.R. 30-46-10.
- **Serious youth injury/illness**: Any youth illness that requires the youth to be hospitalized or receive significant medical treatment. Significant medical treatment is treatment that could not be handled by a trained health care person outside of the hospital or clinical setting.
- **Serious infectious disease**: Diseases such as, but not limited to TB, Hepatitis A/B/C, or a serious sexually transmitted disease as tracked by the Center for Disease Control (CDC). This only needs to be reported if there is a threat of transmission of the disease to staff or other youth.
- **Riot/Hostage situation**: Any disturbance by three or more youth that seriously disturbs the operation of a facility, jeopardizes the control of an area, threatens violence against or destruction of property, or results in significant property damage or personal injury to youth or staff. Includes any hostage situation.
- **Natural disaster**: Acts of nature which cause personal injury to staff and/or youth or which causes structural damage to the physical structure housing youth.
- **AWOL**: A youth's departure from a placement or supervision without lawful authority, as defined by K.S.A. 75-712f. This also includes youth while on a supervised off grounds setting (i.e. transports, hospital, and medical visits). Reported verbally to law enforcement and the custodial case manager immediately with a written report to the custodial case manager within 24 hours of the event. An immediate verbal notification is to be made to law enforcement and to the custodial case manager when the youth returns or is located.
- **Other**: Any action or situation which would require a response by law enforcement, the fire department, an ambulance or another emergency response provider. Incidents in this category would also include any incident not reported in another category and have the potential for significant media coverage.

If the critical incident involves abuse or neglect, the facility must also follow mandated reporting requirements.

All facilities must have procedures for reporting critical incidents to administrative staff and recording critical incidents in the resident files. An administrative file of critical incidents must be kept by facility.

An administrative file shall be kept by the facility documenting critical incidents that is separate from the documentation in the youth's file.

Section 9: Staff In-Service Training

Each facility must have an in-service orientation/training program for new employees, which is especially directed toward the initial training needs of staff working directly with residents. Documentation of completion of orientation training must be kept in the staff member's personnel file. The in-service orientation program shall provide written documentation that all staff are oriented to the following:

A. Facility policy and procedures manual
B. Facility emergency and evacuation procedures
C. Emergency safety interventions (including management of aggressive or suicidal behavior and orientation to the facility's restraint policies and procedures)
D. The handling of blood borne pathogens
E. Facility discipline standards
F. Abuse/neglect mandatory reporting laws
G. Client record documentation policies and procedures
H. Policies and procedures for resident medication management
I. Resident rights
J. Confidentiality laws
K. Training in CPR/First Aid within 5 months of employment
L. De-escalation techniques
M. The handling of youth in trauma

Each facility shall also have a written annual staff in-service training plan which addresses the annual training needs of all staff having direct contact with residents. This annual training is beyond or in addition to the initial orientation training program. All Emergency Shelter's direct care staff shall have a minimum of twenty-four (24) documented clock hours of in-service training per year. Documentation shall be provided in each staff member's personnel record to include content, amount of time, trainer, and his/her qualifications. Topics shall include but not be limited to:

A. CPR and First Aid
B. Blood borne pathogens
C. Medications
D. Emergency safety interventions
E. Substance use disorder patterns
F. Childhood and adolescent development (including developmental disorders)
G. Childhood and adolescent psycho-pathology (including such topics as effects of abuse/neglect, reactive attachment disorders, separation anxiety disorders, ADHD)
H. Childhood and adolescent sexuality issues, especially the effects of early sexual abuse.
I. De-escalation techniques
J. The handling of youth in trauma

Section 10: Record Keeping Requirements for the Facility

The record keeping requirements of K.A.R. 28-4-272 shall be met by the facility.

Record Retention:

Case records, including medical records, shall be maintained 6 years from the date of the youth's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

Health Records:

Health Care records of residents must meet the requirements of K.A.R. 28-4-275.

Chart Documentation:

A dated record of daily observations and significant occurrences involving each youth shall be maintained. The record shall include events, which may affect the well-being of the youth. The record shall be available for review. Each report shall include the date and time of occurrence, the staff member and/or youth involved, the nature of the incident and the circumstances surrounding it.

Progress Reports:

Within the first 14 days of the youth's admission, the Emergency Shelter shall complete a written update of the child or youth's wellbeing and progress in placement, and a written recommendation regarding appropriate placement options for the child or youth. This written report shall be provided to the youth's case manager. Progress reports shall be completed every 14 days thereafter until the child or youth leaves emergency shelter placement. Progress reports shall document progress on specific short-term goals, describe significant revisions in goals and strategies, and specify any changes in placement recommendation during the period covered. All progress reports are placed in the child or youth's file.

Permanency Planning:

Includes the evaluation and design of an approach for the youth and family that focuses on opportunities for the youth to have ongoing active and meaningful connections with family, kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the youth's custodial case manager. The permanency plan shall include strategies and tasks to accomplish the youth's goals. Behaviors which place the youth at risk for disruption, activities to prepare the youth's family or kinship network for reunification, identification of other less restrictive living environments and preparing the youth for transition to these settings shall be addressed.

RESIDENTIAL MATERNITY CARE STANDARDS

Section 1: General Program Description and Requirements

A Residential Maternity Care (RMC) facility is a 24-hour group home or residential facility that meets the requirements of K.A.R. 28-4-268-280. It is non-secure residential services whose primary purpose is devoted to the maintenance and counseling of pregnant youth who need services related to their pregnancy, and planning and care for the unborn child through labor, delivery and postnatal care. RMC's providing care for pregnant youth must meet the requirements of K.A.R. 28-4-279. RMC's providing care for post-partum youth and infants must meet the requirements of K.A.R. 28-4-280.

Section 1.1: Services Provided in Residential Maternity Care

The range of services to be delivered by the RMC facility to meet the variety of individual needs of the residents shall be clearly defined. The General Program description approved by SRS Children and Family Services or JJA for each facility shall include but not be limited to the goals of the program, resident behavioral treatment system, job descriptions (responsibilities, functions, and qualifications), policies and procedures, daily living activities, health services including pre and post natal care, parenting education, recreation activities, and visitation policies.

Section 2: General Staffing Requiremients

Twenty-four hour care which has been licensed by KDHE (K.A.R. 28-4-268-280) as a residential center to cover the programming the facility will provide to the population of children/youth whom the facility will serve. RMC's providing care for pregnant youth must meet the requirements of K.A.R. 28-4-279. RMC's providing care for post-partum youth and infants must meet the requirements of K.A.R. 28-4-280.

- Program plan development, review, and case supervision are carried out by the RMC's Case Coordinator. The youth to case coordinator ratio in a RMC is 1:16. The Case Coordinator shall have at least a bachelor's degree in one of the human service fields (social work, psychology, human development and family life, criminal justice, counseling), nursing, or education. Facility staff must be trained to effectively meet the special needs of youth who require this level of care.
- Facility child care staff shall be at least 21 years of age with a minimum of three years age difference between the child care worker and oldest resident who can be admitted to the facility. Child care staff must have completed 32 hours of in-service training provided by the facility before they can function independently.
- There shall be 24-hour awake staff to insure child safety if licensed as a residential center.

Section 3: Criteria for the Youth's Admission

Population Served:

- Population served is pregnant or post-partum mothers thru age 22, who:
  - Display a need for more structure and supervision than provided in a family foster home due to behaviors which might include difficulty with authority figures, minor offenses, and difficulty in school.
  - And child who is not a recipient of TAF.
  - RMC facilities may also serve those children and youth in Police Protective Custody.
- Youth awaiting a PRTF screen may reside in a RMC until the time of the screen.
- If a youth is in a RMC awaiting a screen the screen must be completed within 14 days, but should be completed as soon as possible. If the youth screens into a PRTF they can stay up to 14 days while awaiting a PRTF bed.
- No more than 50 percent of the youth in a RMC facility may have screened into a PRTF and be in the 14 day waiting period for a PRTF placement.

- Youth may step down to a RMC from a PRTF after the screener and treatment team have determined the youth no longer needs the level of care provided by a PRTF.

Section 3.1: Placement Agreement

A Placement Agreement must be completed between the RMC and the referring agency. A copy of the Placement Agreement must be kept in the youth's file at the facility.

The initial service authorization period for a RMC stay will be for 90 days. Service extensions will be for a period of time not to exceed 60 days, and will be examined by the youth's custodial case manager to ensure the youth is receiving the services they need to reintegrate into the community. The youth may continue receiving services in the RMC facility as long as they continue to require this level of care as determined by the youth's custodial case manager.

Section 4: Resident Lodging

In order to support the daily management and administration of residents, each residential provider shall develop an objective procedure regarding the physical housing of juvenile offenders. Youth placed in a residential setting shall be assigned to a room based upon various factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning rooms shall include (but are not limited to):

- Risk to recidivate (as determined by evidence-based risk assessments)
- Suicidal tendencies
- Level of specialized needs (i.e. mental health, medical, etc.)
- Sex offender status
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc.)
- Vulnerability to being victimized by others (i.e. physical stature)

While each youth will have an individualized program plan, assigning rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and effective management of the living units.

Section 5: Residential Care Program

Section 5.1: Residential Care System

Each RMC shall have a written program of consistent rules and regulations guiding and governing the daily behavior of the youth under the care of the program. The behavior management system should include a description of daily general routines of the program. The system of rules, rewards, and consequences for given behaviors should be identified. Each youth shall be oriented to the RMC's behavior management system by a staff member during the admission or orientation process. Notation shall be made in the youth's file and signed by the youth that the rules and regulations, rewards and consequences have been discussed with the youth.

The RMC facility must post the behavior management system in a common area where youth are able to easily access the system and the youth should be given a written copy of the system to use as a reference. The system should include rules governing interpersonal interactions with staff and peers, facility leave policies, school attendance and behavior while at school, verbal and physical aggression, allowable possessions, awakening and bedtime hours, leisure hours, visitation policies, AWOL attempts, involvement in recreation and other activities, self-destructive behaviors, sexuality, communications with

family and others outside the program, religious worship, involvement in therapies, theft, property destruction, behaviors resulting in mandatory removal from the program, and behaviors at the program which could result in legal prosecution.

The overarching goals should be to not only help the youth adjust to the residential facility but also to daily life within society.

Section 5.2: Education Requirement

All facilities shall have an education agreement with a school district certified by the state board of education. The facility shall ensure routine communications between the staff and any educational program in which the youth is placed. This may include requesting and participating in the development of an Individual Education Plan for each resident when appropriate. These contacts shall be noted in the youth's case record.

Section 5.3: Scope of Services

The provider shall write a policy and procedure manual for the operation of the RMC facility that will be reviewed and approved by SRS Children and Family Services and the Juvenile Justice Authority. It will provide a program for youth in the facility that covers the following program components:

Daily Living Services - Daily living services shall be provided and include the following:

- Room, board, childcare, personal spending money, and school fees.
- Transportation to appointments within a 60-mile radius; including to and from school, medical care, recreation, etc.
- Academic activities - assistance with school work, vocational training, and/or G.E.D. training.

Situational Training- to include but not limited to:

- **Personal Hygiene** – Teaching about body cleanliness, use of deodorants and cosmetics, appropriate clothing, choosing clothing to fit individual and occasion, and keeping clothes neat and clean.
- **Health** - Identifying and understanding residents' health needs; securing and utilizing necessary medical treatment including preventive and health maintenance services; gaining information and education in health maintenance (including preventive measures, nutrition, menstruation, rest, cleanliness, family planning, drugs, sexually transmitted diseases, exercise, and motivation for meeting own health needs), maintaining contact with providers of health services (physician, nurse, clinic) and using outside resources for assistance (clinics, pharmacies, hospitals).
- **Consumer education for independent living-** Budgeting, comparative buying, installment buying, avoiding risks, identifying illegal or excessive interest rates, use of credit, avoiding or dealing with debts, using checking and savings accounts, and paying taxes.

Communication skills:

The youth's articulating thoughts and feelings through appropriate use of such skills as speech, writing and use of the telephone.

Home Management:

Making the bed and changing linens, using the vacuum cleaner, dusting, organizing belongings, disposing of trash, cleaning all areas of the home, operating appliances, cooking complete meals, making simple

repairs, who to call when a major repair is needed, being aware of the need for upkeep, handling emergencies, knowing first aid.

Situational Guidance:

Identifying and accepting strengths, developing patterns of acceptance and coping with authority figures, getting along with others, sharing responsibility, being considerate of others, developing friendships, knowing when to go home when visiting, recognizing or modifying attitudes toward self or others, responsible work attitudes, tolerance of verbal criticism, reactions to praise, punctuality, and attendance.

Recreation:

Participating in leisure time activities, learning how to spend leisure time, developing outside activities, managing time, finding recreation with little or no expense involved, finding community projects to take part in, participating in social groups, participating in sports and games, arts and crafts, and appreciating fine arts.

The daily schedule shall address the needs of the residents and the use of time to enhance the resident's physical, mental, emotional, and social development. The facility shall provide supervised indoor and outdoor recreation so that every resident may participate. Age appropriate equipment to promote physical development and physical fitness shall be available. Age appropriate socialization shall be provided utilizing community resources to assist the youth in transitioning back into their community when appropriate.

Section 5.4: Initial Assessment

When a youth enters the facility, the RMC shall begin assessing their strengths and needs within twenty-four (24) hours and have a completed assessment within 7 days of admission. The assessment shall include but not be limited to the following:

- Reasons for referral to the facility
- Evaluation or assessment covering the following areas:
    - physical health
    - family relations
    - academic or vocational training
    - community life
    - interpersonal interactions
    - daily living skills
    - immediate incidental mental health/substance use disorder service needs.

Section 5.5: Accessing Outpatient Mental Health/Substance Use Disorder Services

Only Outpatient Mental Health/Substance Use Disorder services are allowed while a youth is residing in an out of home placement (excluding PRTF placement). If outpatient services are needed, the provider shall coordinate assessments and services through SRS behavioral health managed care program associates of the Prepaid Ambulatory Health Plan (PAHP) and/or of the Prepaid Inpatient Health Plan (PIHP). The PAHP and PIHP associates will determine the type, frequency and duration of services required to meet the individualized Mental Health/Substance Use Disorder needs of each youth.

Upon admission or during the course of the youth's stay, if the youth begins to exhibit behavior/needs which cannot be addressed by the placement or through outpatient services, the provider shall collaborate with the custodial case manager to obtain an appropriate screen/assessment to determine the level of services required.

If the youth is receiving Mental Health/Substance Use Disorder services from a PAHP or PIHP associate, including a community mental health center or independent practitioner, at the time of admission, the youth may continue services by the same provider to maintain continuity of service.
Providers may employ, contract or otherwise partner with associates of the PAHP and/or PIHP to provide Outpatient Mental Health/Substance Use Disorder services to youth residing at the program.

Providers shall not prohibit the youth's ability to request or receive services from any willing provider who are authorized associates of the PAHP or PIHP.

Section 5.6: Program Plan

Each youth residing in a residential facility must have a program plan that is based on a thorough assessment. Assessment documents must be included in the case record. The program plan shall be established by the end of 14 days from admission and shall address the identified needs in the emotional, physical, educational, social, familial, and where appropriate independent living skill domains. Youth may not have identified needs in every domain. If so, note that no needs were identified. Program plans should be updated when new needs are identified or when program goals are met. Program plans should be thoroughly reviewed and revisions made at the case review conferences within 30 days of admission and each 30 days thereafter. Information obtained from the youth, parent, guardian, and custodial case manger shall be considered in the report.

The program plan shall include individualized services to match the youth's identified needs in the following areas:

- Long term goals in the areas of physical health, family relations, daily living skills, academic and/or vocational skills, interpersonal relations, and emotional/psychological health.
- Short term goals which will help a youth eventually reach his/her long term goals in each of the above areas.
- Services to meet independent living goals.
- Specific plans for reaching the short-term goals including services to be provided and frequency.
- Estimated time for reaching short term goals.
- The youth's signature on the plan indicating that the youth has participated in the development of the program plan.

Section 5.7: Discharge/Aftercare Plan

Discharge planning shall begin upon admission of the youth to the facility. At a minimum, the resident, the resident's parents or guardian, and the placing agency should be involved in planning the discharge of a resident from the facility. The discharge plan and modifications to it should be noted in the case file.

A discharge summary shall be completed at the time of the youth's discharge. This shall include documentation of after-care plans and the goals which the youth has reached in the RMC. Written recommendations for aftercare shall be made and should specify the nature, frequency, and duration or services the facility recommends for the youth. The plan shall also document who the responsible parties are for aftercare services.

Section 5.8: Case Coordination

The RMC's case coordinator has the responsibility for coordinating the youth's program and progress with school, employer, family, and other appropriate community resources.

The Case Coordinator will maintain a resource base of services to address the needs identified in Individual Program Plans.

Section 5.9: Home Visits

When home visits are a part of the program plan, there shall be pre and post home visit contacts between the youth, their family, and facility program staff regarding the home visit including written documentation pre and post regarding the home visit. Because the goal of placement is to return the youth to a family-like setting, it is important that home visits be carefully planned and executed in the best interests of permanency planning for the youth. All home visits shall be arranged through coordination with the child's custodial case manager.

Section 6: Resident's Rights

The staff of the facility shall allow privacy for each youth. The facility's space and furnishings shall be designed and planned with respect for the resident's right to privacy. The facility's design shall also provide supervision according to the ages and needs of the residents. Each resident shall have a quiet area where they can withdraw from the group when appropriate.

Contacts between the resident and their parents/guardian shall be allowed while the resident is in care unless the rights of the parents have been terminated by court order or family contact is not in the resident's best interest. The frequency of contact shall be determined by the needs of the resident and his/her family or guardians per program plan requirements.

The facility shall have clearly written policies regarding visits, gifts, mail, E-mail and telephone (including cell phone) calls between the resident and their family, or guardian. These policies shall be made known to the resident and his/her family/guardian at or prior to admission.

Residents shall be allowed to send and receive mail and have telephone conversations with family members/guardians unless it is not in the best interest of the youth, the safety and security of facility, or if a court order necessitates restrictions.

If restrictions on communications or visits are necessary these shall be documented in the youths program plan and reviewed at the 30-day case reviews. The youth's custodial case manager must be notified of any new restrictions to communications or visitation implemented by the facility prior to its implementation.

A resident shall be allowed to bring personal possessions to the facility and may acquire other possessions in accordance with the policies of the facility. Prior to admission, information shall be made available to the youth and their parents/guardians concerning what possessions a youth may bring to the facility and the kinds of gifts they may receive. Possessions, which a youth cannot have or receive at the facility, shall be specified in writing and distributed to the youth and their parents/guardians.

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Youth shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Youth shall not be subjected to remarks that belittle or ridicule them or their families. Residents shall not be denied food, mail, or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. Only staff members shall discipline residents.

Section 7: Special Circumstances Affecting Youth in Residential Maternity Placement

Section 7.1: Time Out

A procedure used to assist the individual to regain emotional control by removing the individual from his or her immediate environment and restricting the individual to a quiet area or unlocked quiet room.

Application of time out:

1. A resident in time out must never be physically prevented from leaving the time out area.
2. Time out may take place away from the area of activity or from other residents.
3. Staff must monitor the resident while he or she is in time out.

Section 7.2: Emergency safety intervention

An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age, size, gender physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions must be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a resident from harming self or others by exerting external control over physical movement.

Physical restraint is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a resident's body. **Physical restraint should be used only as last resort after all verbal de-escalation techniques have failed and when the resident is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the resident's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in RMC residential facilities.**

Each facility must have a written restraint policy and all staff must be trained to provide safe physical restraints in the event of an emergency safety intervention. Staff must be trained in authorized, well-recognized training programs for managing aggressive behavior. Staff training records must be kept as part of the staff member's personnel file and must be made available upon request. At the time of admission to a facility, the resident and parent/guardian must be oriented to the restraint policies of the facility and must sign a written acknowledgment or this orientation. This written acknowledgment shall be kept in the client's case record.

Section 7.3: Reporting Abuse/Neglect

Physical Abuse means the infliction of physical harm on a child or the causation of a child's deterioration, or the likelihood of harm or deterioration. K.A.R. 30-46-10

Sexual Abuse means any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include allowing, permitting, or encouraging a child to engage in prostitution or to be photographed, filmed, or depicted in obscene or pornographic material. Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity, or coercion. K.A.R. 30-46-10

Mental or Emotional Abuse means the infliction of mental or emotional harm to a child or the causation of a child's deterioration. This term may include, but shall not be limited to, maltreatment or exploitation of a child to the extent the child's health is likely to be harmed.

This term may include the following:

1. terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;
2. emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child;

3. corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behaviors. K.A.R. 30-46-10

Neglect means any act or omission by a parent, guardian or person responsible for the care of a child resulting in harm to a child or presenting a likelihood of harm and the acts or omissions are not due solely to the lack of financial means of a child's parent or other custodian. Neglect may include but, shall not be limited to:

1. failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;
2. failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or the likelihood of harm to the child; or
3. failure to use resources available to treat a diagnosed medical condition if the treatment will make the child substantially more comfortable, reduce pain and suffering, correct or substantially diminish a crippling condition, or prevent the condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202(t)

Section 7.4: Mandated Reporters

Mandated reporters must report all witnessed or suspected abuse/neglect to SRS through the SRS Kansas Abuse/Neglect Hotline.

K.S.A. 38-2223 states that when any of the following persons has reason to suspect that a child has been harmed as a result of physical, mental or emotional abuse or neglect or sexual abuse, the person shall report the matter promptly:

A. The following persons providing medical care or treatment: Persons licensed to practice the healing arts, dentistry and optometry; persons engaged in postgraduate training programs approved by the state board of healing arts; licensed professional or practical nurses; and chief administrative officers of medical care facilities;

B. The following persons licensed by the state to provide mental health services: Licensed psychologists, licensed masters level psychologists, licensed clinical psychotherapists, licensed social workers, licensed marriage and family therapists, licensed clinical marriage and family therapists, licensed professional counselors, licensed clinical professional counselors and registered alcohol and drug abuse counselors;

C. Teachers, school administrators or other employees of an educational institution which the child is attending and persons licensed by the secretary of health and environment to provide child care services or the employees of persons so licensed at the place where the child care services are being provided to the child; and

D. Firefighters, emergency medical services personnel, law enforcement officers, juvenile intake and assessment workers, court services officers and community corrections officers, case managers appointed under K.S.A. 23-1001 et seq., and amendments thereto, and mediators appointed under K.S.A. 23-602, and amendments thereto.

Abuse/neglect reported or witnessed in any Residential Maternity Home must be immediately reported to the youth's custodial case manager and SRS through the SRS Kansas Abuse/Neglect Hotline (1-800-922-5330). The Abuse/Neglect Hotline number must be posted in a prominent place in the facility. Any employee of the facility who witnesses or hears about the abuse/neglect of a resident within that facility is to notify the Director of the facility immediately, except in cases where the alleged perpetrator is the

facility Director. The facility Director is responsible to see to it that all cases of abuse/neglect are reported to them and are passed on to the resident's custodial case manager and SRS through the SRS Kansas Abuse/Neglect Hotline. At no time shall the administration of a program in which abuse/neglect has allegedly occurred interfere or otherwise attempt to alter the report of an abuse/neglect claim made by an employee of that facility.

Section 8: Critical Incident

A Critical Incident is an occurrence that requires the provider to make a response that is not a part of the program's ordinary daily routine.

Section 8.1: Critical Incident Reporting

Critical incidents are to be reported to the youth's custodial case manager and the youth's parent or guardian when appropriate.

"Each facility shall develop an internal process for obtaining on-call/emergency contact information for all custodial case managers in the event of an emergency or critical incident."

The following critical incidents should be verbally reported immediately with a written report to the custodial case manager within 24 hours of the event (please refer to the following definitions for clarification):

- **Attempted suicide**: The attempt to intentionally kill oneself and the attempt caused injury or could have resulted in serious injury or death if not detected.
- **Suicide**: Intentionally killing oneself.
- **Homicide**: The killing of one person by another.
- **Other death**: Accidental death or death from natural causes of youth.
- **Assault/Battery**: Verbally creating fear of bodily harm and/or the causing bodily harm against another person.
- **Sexual misconduct**: Any sexual conduct between youth or between youth and staff/volunteers. Sexual conduct includes the intentional touching of another person's intimate parts, or the clothing covering the immediate area of the intimate parts, committed with sexual or aggressive intent.
- **Alleged maltreatment of youth**: Any act or situation of abuse and/or neglect, as defined by K.A.R. 30-46-10.
- **Serious youth injury/illness**: Any youth illness that requires the youth to be hospitalized or receive significant medical treatment. Significant medical treatment is treatment that could not be handled by a trained health care person outside of the hospital or clinical setting.
- **Serious infectious disease**: Diseases such as, but not limited to TB, Hepatitis A/B/C, or a serious sexually transmitted disease as tracked by the Center for Disease Control (CDC). This only needs to be reported if there is a threat of transmission of the disease to staff or other youth.
- **Riot/Hostage situation**: Any disturbance by three or more youth that seriously disturbs the operation of a facility, jeopardizes the control of an area, threatens violence against or destruction of property, or results in significant property damage or personal injury to youth or staff. Includes any hostage situation.
- **Natural disaster**: Acts of nature which cause personal injury to staff and/or youth or which causes structural damage to the physical structure housing youth.
- **AWOL**: A youth's departure from a placement or supervision without lawful authority, as defined by K.S.A. 75-712f. This also includes youth while on a supervised off grounds setting (i.e. transports, hospital, and medical visits). Reported verbally to law enforcement and the custodial case manager immediately with a written report to the custodial case manager within 24

hours of the event. An immediate verbal notification is to be made to law enforcement and to the custodial case manager when the youth returns or is located.

- **Other**: Any action or situation which would require a response by law enforcement, the fire department, an ambulance or another emergency response provider. Incidents in this category would also include any incident not reported in another category and have the potential for significant media coverage.

If the critical incident involves abuse or neglect, the facility must also follow mandated reporting requirements.

All facilities must have procedures for reporting critical incidents to administrative staff and recording critical incidents in the resident files. An administrative file of critical incidents must be kept by facility.

An administrative file shall be kept by the facility documenting critical incidents that is separate from the documentation in the youth's file.

Section 9: Staff In-Service Training

Youth care staff shall be provided with a minimum of 24 documented clock hours per year which include, but are not limited to, training in human sexuality, behavior management, discipline, child and infant development, health care, and techniques in the prevention and treatment of drug and alcohol abuse.

Section 10: Record Keeping Requirements for the Facility

The record keeping requirements of K.A.R. 28-4-272 shall be met by the facility. In addition, the following shall be kept by the facility.

Record Retention:

Case records, including medical records, shall be maintained for 6 years from the date of the youth's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

Chart Documentation:

A dated record of daily observations and significant occurrences involving each youth shall be maintained. The record shall include events, which may affect the well-being of the youth. The record shall be available for review. Each report shall include the date and time of occurrence, the staff member and/or youth involved, the nature of the incident and the circumstances surrounding it.

Weekly Progress Notes:

Notes shall be completed by the case coordinator and staff providing services. These notes must be entered into the youth's chart, reflecting the delivery of services according to the program plan. This documentation must address the youth's responses to interventions and the progress of the youth on individualized goals and objectives. The note should include any significant events that occurred during the week and should also summarize contacts with family members and other involved agencies. If an unmet need is identified, the note must reflect the actions to be taken to revise the plan for the youth to meet that need.

Health Records:

Health Care and Records of residents must meet the requirements of K.A.R. 28-4-275.

Progress Reports:

Thirty-day progress reports shall document progress on specific short-term goals, describe significant revisions in goals and strategies, and specify any new program goals and strategies during the period covered. The 30-day progress reports shall summarize progress and note changes regarding long-term placement and program goals and shall be provided to the referring agency.

Permanency Planning:

Includes the evaluation and design of an approach for the youth and family that focuses on opportunities for the youth to have ongoing active and meaningful connections with family, kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the youth's custodial case manager and be included in the program plan to be reviewed every 30 days. The permanency plan shall include strategies and tasks to accomplish the youth's goals. Behaviors which place the youth at risk for disruption, activities to prepare the youth's family or kinship network for reunification, identification of other less restrictive living environments and preparing the youth for transition to these settings shall be addressed.

TRANSITIONAL LIVING PROGRAM (TLP) STANDARDS

Section 1: General Program Description

Transitional living is designed for youth who are ready to enter a phase of care that will eventually transition them to independent living. Transitional living affords youth an opportunity to practice basic independent living skills in a variety of settings with decreasing degrees of supervision.

Section 1.1: Transitional Living Program (TLP)

- Youth reside in apartments within one building or complex (contained apartments). Each youth must be afforded sufficient bedroom space to insure adequate privacy, safety and security.
- The provider must insure the environmental safety of the apartment is in compliance with local over sight agencies such as HUD, Fire Marshall, Municipalities, Apartment Management, etc.
- Service Access plan development, review, and case supervision are carried out by the Transitional Living provider. The youth to case coordinator ratio for Transitional living is no more than 1:16.
- Services will be designed to work in collaboration with other community-based providers to develop a strong foundation of service and support access.
- Staff shall have experience, skill and knowledge in adolescent development, behavior management, child abuse and neglect, family dynamics, provision of community-based services, development of youth's strengths and assets, and positive youth development.
- The provider must provide assistance to ensure that youth obtain the basic necessities of daily life.
- The provider must offer or arrange for strength-based interventions to address crisis and or daily living situations.
- The provider must facilitate development of support systems to increase the youth's interdependency within the community in which they reside.
- All services accessed shall be appropriate to the age, gender, sexual orientation, cultural heritage, developmental and functional level, as well as the learning ability of each youth.
- Admission requirements shall include a list of support service needs as identified by the referring agency.

Section 2: Admission Skills Required

Prior to consideration for admission to any TLP service youth **MUST** be able to demonstrate knowledge of basic life skills. Youth in TLP services must be provided the opportunity to practice the skills necessary to live independently. These skills, at a minimum, shall include:

- Preparing meals and basic nutrition education
- Doing laundry
- Maintaining a clean, orderly, and safe living space
- Living cooperatively with other housemates or neighbors
- Handling landlord/tenant complaints
- Controlling guests' behavior
- Handling basic maintenance, simple repairs, and how to call the landlord about problems
- Developing and following a budget
- Access to routine transportation (e.g., public transportation, carpool)
- Shopping, food preparation, food storage, and consumer skills

Section 3: Transitional Living Program Staffing

Staff must meet the qualifications and responsibilities as set forth in this document. Written job descriptions shall be developed for all staff and maintained on site where personnel functions are carried out.

Section 3.1: Administrator

- Qualifications
  - The administrator shall have a Bachelor's degree and prior administrative experience.
  - Shall not be a person restricted from working with youth as defined by K.S.A. 65-516.
  - Shall have a working knowledge of adolescent development principles.

- Responsibilities
  - Shall be responsible for working with, supervising and training other staff (e.g., case coordinator, life coach) who are working with youth in the transitional living program.

Section 3.2: Case Coordinator

- Qualifications
  - The Case Coordinator shall have at least a bachelor's degree in one of the human service fields (social work, psychology, human development and family life, criminal justice, counseling, nursing or education) and a working knowledge of adolescent development principles.
  - Shall be at least twenty-one (21) years of age and at least three years older than the oldest youth served.
  - Shall not be a person restricted from working with youth as defined by K.S.A. 65-516.

- Responsibilities
  - Service Access plan development, review, and development of collaborations with community-based service providers.
  - Shall be responsible for any direct supervision of youth as required.
  - Shall inspect youth's apartment as needed to insure the safety and security of youth.
  - Shall coordinate or provide alternative transportation as deemed necessary.
  - Shall complete paperwork or reports to referring agency as required.
  - Shall work in partnership with life coaches.

Section 3.3: Life Coach

Qualifications

- Life Coaches shall have at least a high school diploma or equivalent and have a working knowledge of adolescent development principles.
- Shall be at least twenty-one (21) years of age and at least three years older than the oldest youth served.
- Shall not be a person restricted from working with youth as defined by K.S.A. 65-516.

Responsibilities

- Shall work shifts and or be on-call 24 hours a day on a rotating basis.
- Shall be responsible for any direct supervision of youth as required.
- Shall inspect youth's apartment as needed to insure the safety and security of youth.
- Shall be responsible for the day-to-day modeling of life skills (e.g., assertiveness, communication, conflict management, problem solving and decision making).
- Shall monitor youth's daily life skills and provide appropriate feedback.

- Shall work in partnership with the case coordinator.

Section 4: Staff In-Service Training

Each provider must have an in-service orientation/training program for new employees, which is especially directed toward the initial training needs of staff working directly with youth in transitional living. Documentation of completion of orientation training must be kept in the staff member's personnel file. The in-service orientation program shall provide written documentation that all staff is oriented to the following:

- Agency policy and procedure manual
- Facility emergency and evacuation procedures (non-scatter site only)
- Emergency safety interventions
- The handling of blood borne pathogens
- Agency discipline standards
- Abuse/neglect mandatory reporting laws
- Youth record documentation policies and procedures
- Policies and procedures for youth medication management
- Resident rights
- Confidentiality laws
- Training in CPF/First Aid within 3 months of employment
- De-escalation techniques

Each provider shall also have a written annual staff in-service training plan, which addresses the annual training needs of all staff having direct contact with youth. This annual training is beyond or in addition to the initial orientation-training program. All Transitional living staff shall have a minimum of forty (40) documented clock hours of in-service training per year subsequent to the initial year. Documentation shall be provided in each staff member's personnel record to include content, amount of time, trainer, and his/her qualifications. Topics shall include but are not limited to:

- CPR and First Aid
- Blood borne pathogens
- Medications
- Emergency safety interventions
- Substance use disorder patterns
- Adolescent development (including developmental disorders)
- Adolescent psychopathology (including such topics as effects of abuse/neglect, reactive attachment disorders, separation anxiety disorders, ADHD)
- Childhood and adolescent sexuality issues, especially the effects of early sexual abuse
- De-escalation techniques

Section 5: Placements

Transitional living placements are offered through residential living arrangements where youth have the opportunity to practice independent living skills with decreasing degrees of care and supervision. The youth's case planning team, which must include the youth, is required to determine the youth's readiness to enter this program by a review of the youth's current life skills proficiency. The youth may remain in this level of care until it is determined the youth is ready to transition to a Community Integration Program or a fully independent living setting.

Section 5.1: General Requirements

All youth in transitional living placements must:

- Be at least 16 years of age
- Be working towards full or part-time employment
- Be working towards a diploma or equivalent (if not already obtained)
- Have demonstrated a basic knowledge of life skills
- Youth are required to maintain a savings account to be held in trust by the TLP. Youth shall deposit the full or partial amount (depending upon their employment status) of their share of the monthly apartment rent and utilities. The youth's planning team will determine the actual amount required to be deposited in trust. These monies are then available to the youth when they leave the TLP.

Section 5.2: Home Furnishings/Services

The provider shall make available certain articles and supplies for furnishing the youths residence. The articles and supplies may be new or used, but must be in good condition. The articles and supplies must include, but are not limited to:

- A bed and bed linens;
- A dining table and chairs;
- Living or sitting room furniture;
- A stove and refrigerator;
- Kitchen furnishings (e.g., pots, pans, cooking and eating utensils);
- Basic cleaning supplies;
- Landline telephone;
- Utilities (e.g., water, trash, electricity, gas);
- Access to laundry services;
- Food in sufficient quantity to provide at least three (3) nutritionally balanced meals per day;
- Kitchen and bath linens;
- Entertainment equipment (e.g., television, stereo, video games) are optional, if not provided, youth should be provided the opportunity to purchase these items when they are financially capable;
- Emergency transportation when routine transportation is not available;
- Administration, oversight of youth's trust;
- Financial guidance to youth (e.g., budgeting, consumer skills).

Section 5.3: Positive and Realistic Living Experiences

Youth are further prepared for adulthood by being provided a realistic living experience, through transitional living placements in which they can take increasing responsibility for themselves. Elements of those living experiences include, but are not limited to, the following:

- Direct experience with the consequences of daily actions and decisions;
- Life skills practice while having access to staff for support and advice;
- Daily social contacts;
- Emotional adjustment to the difference between present living situation and previous ones;
- Practice living alone;
- Use of leisure time;
- Obtaining and using transportation to access needed resources.

These experiences must also be tailored to a youth's current level of functioning. Additional experiences and opportunities may be introduced as a youth's skill level increases and more complex opportunities are desired.

Section 5.4 Placement Supervision

All youth in TLP placements shall have twenty-four (24) hour access to on-site program staff that is responsible for monitoring the activities of youth in their programs. Program staff shall develop a schedule for providing supervision with guidance based on a specific youth's maturity, acquired skills, and emotional status. The supervisory schedule shall be designed so that staff may observe that the youth is practicing healthy and responsible life skills and will be developed in collaboration with a youth's referring agency. This collaboration will determine the frequency and type of supervision/support provided to the youth.

Section 5.5: Placement Agreement

A Placement Agreement must be completed between the TLP and the referring agency. A copy of the Placement Agreement must be kept in the youth's file at the facility.

The initial service authorization period for a TLP stay will be for 90 days. Service extensions will be for a period of time not to exceed 60 days, and will be examined by the youth's custodial case manager to ensure the youth is receiving the services they need to reintegrate into the community. The youth may continue receiving services in the TLP facility as long as they continue to require this level of care as determined by the youth's custodial case manager.

Section 6: Resident Lodging

In order to support the daily management and administration of residents, each residential provider shall develop an objective procedure regarding the physical housing of juvenile offenders. Youth placed in a residential setting shall be assigned to a room based upon various factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning rooms shall include (but are not limited to):

- Risk to recidivate (as determined by evidence-based risk assessments)
- Suicidal tendencies
- Level of specialized needs (i.e. mental health, medical, etc)
- Sex offender status
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc)
- Vulnerability to being victimized by others (i.e. physical stature)

While each youth will have an individualized program plan, assigning rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and effective management of the living units.

Section 7: Service/Supports

Youth in transitional living placements may need access to supportive services including but not limited to the following categories:

- Mental health services
- Alcohol and substance use disorder treatment services

- Educational/vocational support services
- Individual counseling
- Sex Offender treatment services
- Pro-social recreational activities
- Preventative, routine and emergency health care
- Routine transportation

Section 7.1: Accessing Outpatient Mental Health/Substance Use Disorder Services

Only Outpatient Mental Health/Substance Use Disorder services are allowed while a youth is residing in an out of home placement (excluding PRTF placement). If outpatient services are needed, the provider shall coordinate assessments and services through SRS behavioral health managed care program associates of the Prepaid Ambulatory Health Plan (PAHP) and/or of the Prepaid Inpatient Health Plan (PIHP). The PAHP and PIHP associates will determine the type, frequency and duration of services required to meet the individualized Mental Health/Substance Use Disorder needs of each youth.

Upon admission or during the course of the youth's stay, if the youth begins to exhibit behavior/needs which cannot be addressed by the placement or through outpatient services, the provider shall collaborate with the custodial case manager to obtain an appropriate screen/assessment to determine the level of services required.

If the youth is receiving Mental Health/Substance Use Disorder services from a PAHP or PIHP associate, including a community mental health center or independent practitioner, at the time of admission, the youth may continue services by the same provider to maintain continuity of service.

Providers may employ, contract or otherwise partner with associates of the PAHP and/or PIHP to provide Outpatient Mental Health/Substance Use Disorder services to youth residing at the program.

Providers shall not prohibit the youth's ability to request or receive services from any willing provider who are authorized associates of the PAHP or PIHP.

Section 8: Service Access Planning

Initial Assessment:

The admission service access request provided by the referring agency shall constitute the initial assessment.

Additional Assessments:

The case coordinator or life skills coach may administer life skills assessments as needed to further identify needs to be addressed in the service access plan.

Plan requirements:

Each youth residing in transitional living must have a service access plan based on needs identified by the provider and the referring agency. Any assessment documents must be included in the case record. The service plan shall be established by the end of 3 working days from admission. Service plans should be updated whenever new needs are identified or when goals are met. Service plans should be reviewed and revisions made at least every 30 days.

The service plan shall include:

- Long-term goals in the areas of physical health, family relations, daily living skills, academic and/or vocational skills, interpersonal relations, and emotional/psychological health as appropriate.
- Short-term goals that help the youth reach his/her long-term goals in the areas identified above.
- Estimated time for reaching short-term goals.
- Youth's signature indicating his/her participation in the development of the service plan.

The service plan shall be reviewed, revised, and documented in a progress report at least every 30 days by the facility. Information obtained from the youth, parent, guardian, referring agency, employers or service providers shall be considered in the report.

Section 8.1: Discharge/Aftercare Plan

Discharge planning shall begin upon admission of the youth to transitional living. At a minimum, the youth, youth's parent or guardian, and the referring agency should be involved in planning the discharge of a youth. A discharge summary shall be completed at the time of the youth's discharge. This shall include goals that the youth has achieved and any identified plans for aftercare. Written recommendations for aftercare shall be made and should specify the nature, frequency, and duration or services recommended for the youth. The plan shall also identify the parties responsible for specific aftercare services.

Section 9: Resident's Rights

The staff of the facility shall allow privacy for each youth. The facility's space and furnishings shall be designed and planned with respect for the resident's right to privacy. The facility's design shall also provide supervision according to the ages and needs of the residents. Each resident shall have a quiet area where they can withdraw from the group when appropriate.

Contacts between the resident and their parents/guardian shall be allowed while the resident is in care unless the rights of the parents have been terminated by court order or family contact is not in the resident's best interest. The frequency of contact shall be determined by the needs of the resident and his/her family or guardians per program plan requirements.

The facility shall have clearly written policies regarding visits, gifts, mail, E-mail and telephone (including cell phone) calls between the resident and their family, or guardian. These policies shall be made known to the resident and his/her family/guardian at or prior to admission.

Residents shall be allowed to send and receive mail and have telephone conversations with family members/guardians unless it is not in the best interest of the youth, the safety and security of facility, or if a court order necessitates restrictions.

If restrictions on communications or visits are necessary these shall be documented in the youths file. The youth's custodial case manager must be notified of any new restrictions to communications or visitation implemented by the facility prior to its implementation.

A resident shall be allowed to bring personal possessions to the facility and may acquire other possessions in accordance with the policies of the facility. Prior to admission, information shall be made available to the youth and their parents/guardians concerning what possessions a youth may bring to the facility and the kinds of gifts they may receive. Possessions, which a youth cannot have or receive at the facility, shall be specified in writing and distributed to the youth and their parents/guardians.

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Youth shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Youth shall not be subjected to remarks that belittle or ridicule them or their families. Residents shall not be denied food, mail, or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. Only staff members shall discipline residents.

Section 10: Record Keeping Requirements for the Facility

Section 10.1: Chart Documentation

A dated record of daily observations and significant occurrences involving each youth shall be maintained. The record shall include events, which may affect the well-being of the youth. The record shall be available for review. Each report shall include the date and time of occurrence, the staff member and/or youth involved, the nature of the incident and the circumstances surrounding it.

Section 10.2: Weekly Progress Notes

Notes shall be completed by the case coordinator and staff providing services. These notes must be entered into the youth's chart, reflecting the delivery of services according to the program plan. This documentation must address the youth's responses to interventions and the progress of the youth on individualized goals and objectives. The note should include any significant events that occurred during the week and should also summarize contacts with family members and other involved agencies. If an unmet need is identified, the note must reflect the actions to be taken to revise the plan for the youth to meet that need.

Section 10.3: Health Records

Records of medications shall be kept in each youth's case medical record and include: the name of the prescribing physician, the name of the medication, the dosage prescribed, the medication schedule, the purpose of the medication, noted side effects, the date of the prescription, and the date prescribed by a physician. A record of medication given, amount, date and time, and person dispensing shall be recorded. All doctor and dental visits, major illnesses, and accidents shall be recorded. Mental health appointments shall also be specifically documented in a youth's medical record. This provides for a complete Health record for the youth and their family, which documents the frequency of the youth's mental health treatment.

Section 10.4: 15 and 30-Day Progress Reports

Within the first 15 days of the youth's admission to the TLP the Case coordinator shall provide written placement recommendations to the youth's custodial case managers as well as an update on the youth's progress. This report shall be placed in the youth's file. Thirty-day progress reports shall document progress on specific short-term goals, describe significant revisions in goals and strategies, and specify any new program goals and strategies during the period covered. The 30-day progress reports shall summarize progress and note changes regarding long-term placement and program goals and shall also be placed in the youth's file.

Section 10.5: Permanency Planning

Includes the evaluation and design of an approach for the youth and family that focus on opportunities for the youth to have ongoing active and meaningful connections with family, kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the youth's custodial case manager. The permanency plan shall include strategies and tasks to accomplish the youth's goals. Behaviors which place the youth at risk for disruption, activities to prepare the youth's family or kinship

network for reunification, identification of other less restrictive living environments and preparing the youth for transition to these settings shall be addressed.

Section 10.6: Record Retention

Case records, including medical records, shall be maintained 6 years from the date of the youth's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

Section 11: Special Circumstances Affecting Youth in Residential Placement

Section 11.1: Time Out

A procedure used to assist the individual to regain emotional control by removing the individual from his or her immediate environment and restricting the individual to a quiet area or unlocked quiet room.

Application of time out:

1. A resident in time out must never be physically prevented from leaving the time out area.
2. Time out may take place away from the area of activity or from other residents.
3. Staff must monitor the resident while he or she is in time out.

Section 11.2: Emergency safety intervention:

An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age, size, gender, physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions must be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a resident from harming self or others by exerting external control over physical movement.

Physical restraint is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a resident's body. **Physical restraint should be used only as last resort after all verbal de-escalation techniques have failed and when the resident is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the resident's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in TLP services.**

Each facility must have a written restraint policy and all staff must be trained to provide safe physical restraints in the event of an emergency safety intervention. Staff must be trained in authorized, well-recognized training programs for managing aggressive behavior. Staff training records must be kept as part of the staff member's personnel file and must be made available upon request. At the time of admission to a facility, the resident and parent/guardian must be oriented to the restraint policies of the facility and must sign a written acknowledgment or this orientation. This written acknowledgment shall be kept in the client's case record.

Section 11.3: Reporting Abuse/Neglect

Physical Abuse means the infliction of physical harm on a child or the causation of a child's deterioration, or the likelihood of harm or deterioration. K.A.R. 30-46-10

Sexual Abuse means any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include allowing, permitting, or encouraging a child to engage in prostitution or to be photographed, filmed, or depicted in obscene or pornographic material. Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity, or coercion. K.A.R. 30-46-10

Mental or Emotional Abuse means the infliction of mental or emotional harm to a child or the causation of a child's deterioration. This term may include, but shall not be limited to, maltreatment or exploitation of a child to the extent the child's health is likely to be harmed.

This term may include the following:

1. terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;
2. emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child;
3. corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behaviors. K.A.R. 30-46-10

Neglect means any act or omission by a parent, guardian or person responsible for the care of a child resulting in harm to a child or presenting a likelihood of harm and the acts or omissions are not due solely to the lack of financial means of a child's parent or other custodian. Neglect may include but, shall not be limited to:

1. failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;
2. failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or the likelihood of harm to the child; or
3. failure to use resources available to treat a diagnosed medical condition if the treatment will make the child substantially more comfortable, reduce pain and suffering, correct or substantially diminish a crippling condition, or prevent the condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202(t).

Section 11.4: Mandated Reporters

Mandated reporters must report all witnessed or suspected abuse/neglect to SRS through the SRS Kansas Abuse/Neglect Hotline.

K.S.A. 38-2223 states that when any of the following persons has reason to suspect that a youth has been harmed as a result of physical, mental or emotional abuse or neglect or sexual abuse, the person shall report the matter promptly:

A. The following persons providing medical care or treatment: Persons licensed to practice the healing arts, dentistry and optometry; persons engaged in postgraduate training programs approved by the state board of healing arts; licensed professional or practical nurses; and chief administrative officers of medical care facilities;

B. The following persons licensed by the state to provide mental health services: Licensed psychologists, licensed masters level psychologists, licensed clinical psychotherapists, licensed social workers, licensed marriage and family therapists, licensed clinical marriage and family therapists, licensed professional counselors, licensed clinical professional counselors and registered alcohol and drug abuse counselors;

C. Teachers, school administrators or other employees of an educational institution which the youth is attending and persons licensed by the secretary of health and environment to provide youth care services or the employees of persons so licensed at the place where the youth care services are being provided to the youth; and

D. Firefighters, emergency medical services personnel, law enforcement officers, juvenile intake and assessment workers, court services officers and community corrections officers, case managers appointed under K.S.A. 23-1001 et seq., and amendments thereto, and mediators appointed under K.S.A. 23-602, and amendments thereto.

Abuse/neglect reported or witnessed in any Transitional Living Program must be immediately reported to the youth's custodial case manager and SRS through the SRS Kansas Abuse/Neglect Hotline (1-800-922-5330). The Abuse/Neglect Hotline number must be posted in a prominent place in the facility. Any employee of the facility who witnesses or hears about the abuse/neglect of a resident within that facility is to notify the Director of the facility immediately, except in cases where the alleged perpetrator is the facility Director. The facility Director is responsible to see to it that all cases of abuse/neglect are reported to them and are passed on to the resident's custodial case manager and SRS through the SRS Kansas Abuse/Neglect Hotline. At no time shall the administration of a program in which abuse/neglect has allegedly occurred interfere or otherwise attempt to alter the report of an abuse/neglect claim made by an employee of that facility.

Section 11.5: Critical Incident

A Critical Incident is an occurrence that requires the provider to make a response that is not a part of the program's ordinary daily routine.

Section 11.6: Critical Incident Reporting

Critical incidents are to be reported to the youth's custodial case manager and the youth's parent or guardian when appropriate.

"Each TLP provider shall develop an internal process for obtaining on-call/emergency contact information for all custodial case managers in the event of an emergency or critical incident."

The following critical incidents should be verbally reported immediately with a written report to the custodial case manager within 24 hours of the event (please refer to the following definitions for clarification):

- **Attempted suicide**: The attempt to intentionally kill oneself and the attempt caused injury or could have resulted in serious injury or death if not detected.
- **Suicide**: Intentionally killing oneself.
- **Homicide**: The killing of one person by another.
- **Other death**: Accidental death or death from natural causes of youth.
- **Assault/Battery**: Verbally creating fear of bodily harm and/or the causing bodily harm against another person.
- **Sexual misconduct**: Any sexual conduct between youth or between youth and staff/volunteers. Sexual conduct includes the intentional touching of another person's intimate parts, or the clothing covering the immediate area of the intimate parts, committed with sexual or aggressive intent.
- **Alleged maltreatment of youth**: Any act or situation of abuse and/or neglect, as defined by K.A.R. 30-46-10.

- **Serious youth injury/illness**: Any youth illness that requires the youth to be hospitalized or receive significant medical treatment. Significant medical treatment is treatment that could not be handled by a trained health care person outside of the hospital or clinical setting.
- **Serious infectious disease**: Diseases such as, but not limited to TB, Hepatitis A/B/C, or a serious sexually transmitted disease as tracked by the Center for Disease Control (CDC). This only needs to be reported if there is a threat of transmission of the disease to staff or other youth.
- **Riot/Hostage situation**: Any disturbance by three or more youth that seriously disturbs the operation of a facility, jeopardizes the control of an area, threatens violence against or destruction of property, or results in significant property damage or personal injury to youth or staff. Includes any hostage situation.
- **Natural disaster**: Acts of nature which cause personal injury to staff and/or youth or which causes structural damage to the physical structure housing youth.
- **AWOL**: A youth's departure from a placement or supervision without lawful authority, as defined by K.S.A. 75-712f. This also includes youth while on a supervised off grounds setting (i.e. transports, hospital, and medical visits). Reported verbally to law enforcement and the custodial case manager immediately with a written report to the custodial case manager within 24 hours of the event. An immediate verbal notification is to be made to law enforcement and to the custodial case manager when the youth returns or is located.
- **Other**: Any action or situation which would require a response by law enforcement, the fire department, an ambulance or another emergency response provider. Incidents in this category would also include any incident not reported in another category and have the potential for significant media coverage.

If the critical incident involves abuse or neglect, the facility must also follow mandated reporting requirements.

All facilities must have procedures for reporting critical incidents to administrative staff and recording critical incidents in the resident files. An administrative file of critical incidents must be kept by facility.

An administrative file shall be kept by the facility documenting critical incidents that is separate from the documentation in the youth's file.

COMMUNITY INTEGRATION PROGRAM (CIP) STANDARDS

Section 1: General Program Description

Community Integration is a service designed for youth who are ready to enter a phase of care, which will eventually transition them to independent living. Youth reside in apartments and are afforded the opportunity to practice independent living skills with decreasing degrees of supervision. Community Integration service is to prepare youth to become socially and financially independent from the program.

Section 1.1: Community Integration Program (CIP)

Community Integration is non-secure residential settings designed for youth who are ready to enter a phase of care, which will eventually transition them to independent living. It is a service that allows youth the opportunity to practice independent living skills with decreasing degrees of supervision. Community Integration service is to prepare youth to become socially and financially independent from the program.

Section 1.2: General Requirements

- Youth reside in apartments within one building or complex (contained apartments) or scatter site apartments. Each youth shall be afforded sufficient bedroom space to insure adequate privacy, safety and security.
- The provider must insure the environmental safety of the apartment is in compliance with local over sight agencies such as HUD, Fire Marshall, Municipalities, Apartment Management, etc.
- Service Access plan development, review, and case supervision are carried out by the Community Integration Specialist.
- Services will be designed to work in collaboration with other community-based providers to develop a strong foundation of service and support access.
- Staff shall have experience, skill and knowledge in adolescent development, behavior management, child abuse and neglect, family dynamics, provision of community-based services, development of youth's strengths and assets, and positive youth development.
- The provider must provide assistance to ensure that youth obtain the basic necessities of daily life.
- The provider must offer or arrange for strength-based interventions to address crisis and or daily living situations.
- The provider must facilitate development of support systems to increase the youth's interdependency within the community in which they reside.
- All services accessed shall be appropriate to the age, gender, sexual orientation, cultural heritage, developmental and functional level, as well as the learning ability of each youth.
- Admission requirements shall include a list of support service needs as identified by the referring agency.
- Youth is required to maintain a savings account into which the youth deposits the full or partial amount (depending upon their employment status) of their share of the monthly apartment rent and utilities.

Section 2: Admission Skills Required

Prior to consideration for admission to any Community Integration service youth **MUST** be able to evidence the ability to perform basic life skills. These skills, at a minimum, shall include:

- Preparing meals
- Doing laundry

- Maintaining a clean, orderly and safe living space
- Living cooperatively with other housemates or neighbors
- Handling landlord/tenant complaints
- Controlling guests' behavior
- Handling basic maintenance, simple repairs, and how to call the landlord about problems
- Developing and following a budget
- Use of leisure time
- Obtaining and using transportation to access needed resources
- Identify safe and affordable housing, negotiate a lease, present oneself to a landlord, prevent actions that might lead to an eviction and understand landlord/tenant rights and responsibilities

Section 3: Community Integration Program Staffing

Staff must meet the qualifications and responsibilities as set forth in this document. Written job descriptions shall be developed for all staff and maintained on site where personnel functions are carried out.

Section 3.1: Administrator

- Qualifications
  - The administrator shall have a Bachelor's degree and prior administrative experience.
  - Shall not be a person restricted from working with youth as defined by K.S.A. 65-516.
  - Shall have a working knowledge of adolescent development principles.

- Responsibilities
  - Shall be responsible for working with, supervising and training other staff (e.g., Community Integration Specialist) who are working with youth in the community integration program.

Section 3.2: Community Integration Specialist

- Qualifications
  - The Community Integration Specialist shall have at least a bachelor's degree in one of the human service fields (social work, psychology, human development and family life, criminal justice, counseling, nursing or education) and have a working knowledge of adolescent development principles.
  - Shall be at least twenty-one (21) years of age and at least three years older than the oldest youth served.
  - Shall not be a person restricted from working with youth as defined by K.S.A. 65-516.

- Responsibilities
  - Service Access plan development, review, and development of collaborations with community-based service providers.
  - Shall be responsible for any monitoring of youth activities as required.
  - Shall inspect youth's apartment as needed to insure the safety and security of youth.
  - Shall coordinate or provide alternative transportation as deemed necessary.
  - Shall complete paperwork or reports to referring agency as required.
  - Shall work shifts and or be on-call 24 hours a day on a rotating basis.
  - Shall be responsible for the day-to-day modeling of life skills (e.g., assertiveness, communication, conflict management, problem solving, and decision making).
  - Shall monitor youth's daily life skills and provide appropriate feedback.
  - Shall review bank statements, check stubs, etc. to insure youth's adherence to savings requirements

Section 4: Staff In-Service Training

Each provider must have an in-service orientation/training program for new employees, which is especially directed toward the initial training needs of staff working directly with youth in a CIP. Documentation of completion of orientation training must be kept in the staff member's personnel file. The in-service orientation program shall provide written documentation that all staff is oriented to the following:

- Agency policy and procedure manual
- Facility emergency and evacuation procedures (non-scatter site only)
- Emergency safety interventions
- The handling of blood borne pathogens
- Agency discipline standards
- Abuse/neglect mandatory reporting laws
- Youth record documentation policies and procedures
- Policies and procedures for youth medication management
- Resident rights
- Confidentiality laws
- Training in CPF/First Aid within 3 months of employment
- De-escalation techniques

Each provider shall also have a written annual staff in-service training plan, which addresses the annual training needs of all staff having direct contact with youth. All CIP staff shall have a minimum of forty (40) documented clock hours of in-service training per year in the years subsequent to the initial orientation training. Documentation shall be provided in each staff member's personnel record to include content, amount of time, trainer, and his/her qualifications. Topics shall include but are not limited to:

- CPR and First Aid
- Blood borne pathogens
- Medications
- Emergency safety interventions
- Substance use disorder patterns
- Adolescent development (including developmental disorders)
- Adolescent psychopathology (including such topics as effects of abuse/neglect, reactive attachment disorders, separation anxiety disorders, ADHD)
- Childhood and adolescent sexuality issues, especially the effects of early sexual abuse
- De-escalation techniques

Section 5: Placements

Community Integration placements may be offered through a variety of residential living arrangements where youth have the opportunity to evidence independent living skills with decreasing degrees of supervision. Residential living arrangements may include apartments within one building or scattered site housing. Scattered site housing is dwellings (e.g., apartments, town homes, duplexes) that are typically located in the same neighborhood.

Section 5.1: General Requirements

All youth in community integration placements must:

- Be at least 16 years of age
- Be working full or part-time

- Be working towards a diploma or equivalent (if not already obtained)
- Have demonstrated the ability to perform life skills

Section 5.2: Home Furnishings/Services

The provider shall make available certain articles and supplies for furnishing the youths residence. The articles and supplies may be new or used, but must be in good condition. The articles and supplies must include, but are not limited to:

- A bed and bed linens
- A dining table and chairs
- Living or sitting room furniture
- A stove and refrigerator
- Kitchen furnishings (e.g., pots, pans, cooking and eating utensils)
- Basic cleaning supplies
- Landline telephone
- Utilities (e.g., water, trash, electricity, gas)
- Access to laundry services
- Food in sufficient quantity to provide at least three (3) nutritionally balanced meals per day (Food costs included in room and board, youth to be responsible for shopping and food preparation)
- Kitchen and bath linens
- Entertainment equipment (e.g., television, stereo, video games) are optional, if not provided, youth should be provided the opportunity to purchase these items when they are financially capable
- Emergency transportation when routine transportation is not available
- Review of youth's financial records (e.g., bank statements, check stubs) to monitor youth's money management skills

Section 5.3: Positive and Realistic Living Experiences

Youth are further prepared for adulthood by being provided a realistic living experience, through community integration placements in which they can take increasing responsibility for themselves. Elements of those living experiences include, but are not limited to, the following:

- Direct experience with the consequences of daily actions and decisions
- Life skills practice while having access to staff for support and advice
- Use emergency medical procedures
- Negotiating a rental agreement
- Practice in money management and budgeting and
- Experience in shopping, food preparation, food storage, and consumer skills

These experiences must also be tailored to a youth's current level of functioning. Additional experiences and opportunities may be introduced as a youth's skill level increases and more complex opportunities are desired.

Section 5.4: Placement Supervision

All youth in community integration placements shall have twenty-four (24) hour telephone access to community integration staff and an alternate placement in the event the community integration placement is unsuccessful. Community Integration staff shall evaluate, at a minimum, the youth's:

- Safety, health, and overall well-being

- Ability to manage school and work responsibilities without daily supervision
- Ability to follow program and landlord rules
- Ability to use good judgment in daily activities and
- Overall progress toward established goals and desired outcomes

The frequency of contact may vary due to many factors (e.g., readiness for independence; living arrangements chosen; presence or availability of other adults; other factors unforeseen until after placement). The following contact schedule, at a minimum, shall be utilized during the first eight (8) weeks in placement. In person contacts are to be in the youth's apartment.

- 1st Week
  - Daily Phone Contact and minimum of 1 in person contact
- 2nd through 4th Weeks
  - Twice a Week Phone Contact and minimum of 1 in person contact
- 5th through 8th Weeks
  - Once a Week Phone Contact and minimum of 1 in person contact
- After the eighth (8th) week, contact must occur no less often than once a month and the Community Integration Specialist and referring agency must reconvene to determine the necessity of the youth's continued placement.

Section 5.5: Placement Agreement

A Placement Agreement must be completed between the CIP and the referring agency. A copy of the Placement Agreement must be kept in the youth's file at the facility.

The initial service authorization period for a CIP stay will be for 90 days. Service extensions will be for a period of time not to exceed 60 days, and will be examined by the youth's custodial case manager to ensure the youth is receiving the services they need to reintegrate into the community. The youth may continue receiving services in the CIP facility as long as they continue to require this level of care as determined by the youth's custodial case manager.

Section 6: Service/Supports

Youth in community integration placements may need access to supportive services including but not limited to the following categories:

- Mental health services, including treatment to address sexual issues if needed
- Alcohol and substance use disorder treatment services
- Educational/vocational support services
- Individual counseling
- Pro-social recreational activities
- Preventative, routine and emergency health care
- Routine transportation

Section 6.1: Accessing Outpatient Mental Health/Substance Use Disorder Services

Only Outpatient Mental Health/Substance Use Disorder services are allowed while a youth is residing in an out of home placement (excluding PRTF placement). If outpatient services are needed, the provider shall coordinate assessments and services through SRS behavioral health managed care program associates of the Prepaid Ambulatory Health Plan (PAHP) and/or of the Prepaid Inpatient Health Plan (PIHP). The PAHP and PIHP associates will determine the type, frequency and duration of services required to meet the individualized Mental Health/Substance Use Disorder needs of each youth.

Upon admission or during the course of the youth's stay, if the youth begins to exhibit behavior/needs which cannot be addressed by the placement or through outpatient services, the provider shall collaborate with the custodial case manager to obtain an appropriate screen/assessment to determine the level of services required.

If the youth is receiving Mental Health/Substance Use Disorder services from a PAHP or PIHP associate, including a community mental health center or independent practitioner, at the time of admission, the youth may continue services by the same provider to maintain continuity of service.

Providers may employ, contract or otherwise partner with associates of the PAHP and/or PIHP to provide Outpatient Mental Health/Substance Use Disorder services to youth residing at the program.

Providers shall not prohibit the youth's ability to request or receive services from any willing provider who are authorized associates of the PAHP or PIHP.

Section 7: Service Access Planning

Initial Assessment:

The admission service access request provided by the referring agency shall constitute the initial assessment.

Additional Assessments:

The Community Integration Specialist may administer life skills assessments as needed to further identify needs to be addressed in the service access plan.

Plan requirements:

Each youth residing in a CIP must have a service access plan based on needs identified by the provider and the referring agency. Any assessment documents must be included in the case record. The service plan shall be established by the end of 3 working days from admission. Service plans should be updated whenever new needs are identified or when goals are met. Service plans should be reviewed and revisions made at least every 30 days.

The service plan shall include:

- Long-term goals in the areas of physical health, family relations, daily living skills, academic and/or vocational skills, interpersonal relations, and emotional/psychological health as appropriate.
- Short-term goals that help the youth reach his/her long-term goals in the areas identified above.
- Estimated time for reaching short-term goals.
- Youth's signature indicating his/her participation in the development of the service plan.

The service plan shall be reviewed, revised, and documented in a progress report at least every 30 days by the facility. Information obtained from the youth, parent, guardian, referring agency, employers or service providers shall be considered in the report.

Section 7.1: Discharge/Aftercare Plan

Discharge planning shall begin upon admission of the youth to community integration. At a minimum, the youth, youth's parent or guardian (if appropriate), and the referring agency should be involved in planning the discharge of a youth. A discharge summary shall be completed at the time of the youth's

discharge. This shall include goals that the youth has achieved and any identified plans for aftercare. Written recommendations for aftercare shall be made and should specify the nature, frequency, and duration or services recommended for the youth. The plan shall also identify the parties responsible for specific aftercare services.

Section 8: Resident's Rights

The staff of the facility shall allow privacy for each youth. The facility's space and furnishings shall be designed and planned with respect for the resident's right to privacy. The facility's design shall also provide supervision according to the ages and needs of the residents. Each resident shall have a quiet area where they can withdraw from the group when appropriate.
Contacts between the resident and their parents/guardian shall be allowed while the resident is in care unless the rights of the parents have been terminated by court order or family contact is not in the resident's best interest. The frequency of contact shall be determined by the needs of the resident and his/her family or guardians per program plan requirements.

The facility shall have clearly written policies regarding visits, gifts, mail, E-mail and telephone (including cell phone) calls between the resident and their family, or guardian. These policies shall be made known to the resident and his/her family/guardian at or prior to admission.

Residents shall be allowed to send and receive mail and have telephone conversations with family members/guardians unless it is not in the best interest of the youth, the safety and security of facility, or if a court order necessitates restrictions.

If restrictions on communications or visits are necessary these shall be documented in the youths file. The youth's custodial case manager must be notified of any new restrictions to communications or visitation implemented by the facility prior to its implementation.

A resident shall be allowed to bring personal possessions to the facility and may acquire other possessions in accordance with the policies of the facility. Prior to admission, information shall be made available to the youth and their parents/guardians concerning what possessions a youth may bring to the facility and the kinds of gifts they may receive. Possessions, which a youth cannot have or receive at the facility, shall be specified in writing and distributed to the youth and their parents/guardians.

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Youth shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Youth shall not be subjected to remarks that belittle or ridicule them or their families. Residents shall not be denied food, mail, or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. Only staff members shall discipline residents.

Section 9: Record Keeping Requirements for the Facility

Section 9.1: Chart Documentation

A dated record of daily observations and significant occurrences involving each youth shall be maintained. The record shall include events, which may affect the well-being of the youth. The record shall be available for review. Each report shall include the date and time of occurrence, the staff member and/or youth involved, the nature of the incident and the circumstances surrounding it.

Section 9.2: Weekly Progress Notes

Notes shall be completed by the Community Integration Specialist and staff providing services. These notes must be entered into the youth's chart, reflecting the delivery of services according to the program

plan. This documentation must address the youth's responses to interventions and the progress of the youth on individualized goals and objectives. The note should include any significant events that occurred during the week and should also summarize contacts with family members and other involved agencies. If an unmet need is identified, the note must reflect the actions to be taken to revise the plan for the youth to meet that need.

Section 9.3 Health Records

Records of medications shall be kept in each youth's case medical record and include: the name of the prescribing physician, the name of the medication, the dosage prescribed, the medication schedule, the purpose of the medication, noted side effects, the date of the prescription, and the date prescribed by a physician. A record of medication given, amount, date and time, and person dispensing shall be recorded. All doctor and dental visits, major illnesses, and accidents shall be recorded. Mental health appointments shall also be specifically documented in a youth's medical record. This provides for a complete Health record for the youth and their family, which documents the frequency of the youth's mental health treatment.

Section 9.4: 15 and 30-Day Progress Reports

Within the first 15 days of the youth's admission to the CIP program the Community Integration Specialist shall provide written placement recommendations to the youth's custodial case managers as well as an update on the youth's progress. This report shall be placed in the youth's file. Thirty-day progress reports shall document progress on specific short-term goals, describe significant revisions in goals and strategies, and specify any new program goals and strategies during the period covered. The 30-day progress reports shall summarize progress and note changes regarding long-term placement and program goals and shall also be placed in the youth's file.

Section 9.5: Permanency Planning

Includes the evaluation and design of an approach for the youth and family that focuses on opportunities for the youth to have ongoing active and meaningful connections with family, kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the youth's custodial case manager. The permanency plan shall include strategies and tasks to accomplish the youth's goals. Behaviors which place the youth at risk for disruption, activities to prepare the youth's family or kinship network for reunification, identification of other less restrictive living environments and preparing the youth for transition to these settings shall be addressed.

Section 9.6: Record Retention

Case records, including medical records, shall be maintained 6 years from the date of the youth's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

Section 10: Special Circumstances Affecting Youth in Residential Placement

Section 10.1: Time Out

A procedure used to assist the individual to regain emotional control by removing the individual from his or her immediate environment and restricting the individual to a quiet area or unlocked quiet room.

Application of time out:

1. A resident in time out must never be physically prevented from leaving the time out area.
2. Time out may take place away from the area of activity or from other residents.

3. Staff must monitor the resident while he or she is in time out.

Section 10.2: Emergency safety intervention

An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age, size, gender, physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions must be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a resident from harming self or others by exerting external control over physical movement.
Physical restraint is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a resident's body. **Physical restraint should be used only as last resort after all verbal de-escalation techniques have failed and when the resident is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the resident's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in CIP services.**

Each facility must have a written restraint policy and all staff must be trained to provide safe physical restraints in the event of an emergency safety intervention. Staff must be trained in authorized, well-recognized training programs for managing aggressive behavior. Staff training records must be kept as part of the staff member's personnel file and must be made available upon request. At the time of admission to a facility, the resident and parent/guardian must be oriented to the restraint policies of the facility and must sign a written acknowledgment or this orientation. This written acknowledgment shall be kept in the client's case record.

Section 10.3: Abuse/Neglect Reporting

Physical Abuse means the infliction of physical harm on a child or the causation of a child's deterioration, or the likelihood of harm or deterioration. K.A.R. 30-46-10

Sexual Abuse means any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include allowing, permitting, or encouraging a child to engage in prostitution or to be photographed, filmed, or depicted in obscene or pornographic material. Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity, or coercion. K.A.R. 30-46-10

Mental or Emotional Abuse means the infliction of mental or emotional harm to a child or the causation of a child's deterioration. This term may include, but shall not be limited to, maltreatment or exploitation of a child to the extent the child's health is likely to be harmed.

This term may include the following:
1. terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;
2. emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child;
3. corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behaviors. K.A.R. 30-46-10

Neglect means any act or omission by a parent, guardian or person responsible for the care of a child resulting in harm to a child or presenting a likelihood of harm and the acts or omissions are not due solely

to the lack of financial means of a child's parent or other custodian. Neglect may include but, shall not be limited to:

1. failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;
2. failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or the likelihood of harm to the child; or
3. failure to use resources available to treat a diagnosed medical condition if the treatment will make the child substantially more comfortable, reduce pain and suffering, correct or substantially diminish a crippling condition, or prevent the condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202(t)

Section 10.4: Mandated Reporters

Mandated reporters must report all witnessed or suspected abuse/neglect to SRS through the SRS Kansas Abuse/Neglect Hotline.

K.S.A. 38-2223 states that when any of the following persons has reason to suspect that a child has been harmed as a result of physical, mental or emotional abuse or neglect or sexual abuse, the person shall report the matter promptly:

A. The following persons providing medical care or treatment: Persons licensed to practice the healing arts, dentistry and optometry; persons engaged in postgraduate training programs approved by the state board of healing arts; licensed professional or practical nurses; and chief administrative officers of medical care facilities;

B. The following persons licensed by the state to provide mental health services: Licensed psychologists, licensed masters level psychologists, licensed clinical psychotherapists, licensed social workers, licensed marriage and family therapists, licensed clinical marriage and family therapists, licensed professional counselors, licensed clinical professional counselors and registered alcohol and drug abuse counselors;

C. Teachers, school administrators or other employees of an educational institution which the child is attending and persons licensed by the secretary of health and environment to provide child care services or the employees of persons so licensed at the place where the child care services are being provided to the child; and

D. Firefighters, emergency medical services personnel, law enforcement officers, juvenile intake and assessment workers, court services officers and community corrections officers, case managers appointed under K.S.A. 23-1001 et seq., and amendments thereto, and mediators appointed under K.S.A. 23-602, and amendments thereto.

Abuse/neglect reported or witnessed in any Community Integration Program must be immediately reported to the youth's custodial case manager and SRS through the SRS Kansas Abuse/Neglect Hotline (1-800-922-5330). The Abuse/Neglect Hotline number must be posted in a prominent place in the facility. Any employee of the facility who witnesses or hears about the abuse/neglect of a resident within that facility is to notify the Director of the facility immediately, except in cases where the alleged perpetrator is the facility Director. The facility Director is responsible to see to it that all cases of abuse/neglect are reported to them and are passed on to the resident's custodial case manager and SRS through the SRS Kansas Abuse/Neglect Hotline. At no time shall the administration of a program in which abuse/neglect has allegedly occurred interfere or otherwise attempt to alter the report of an abuse/neglect claim made by an employee of that facility.

Section 10.5: Critical Incident

A Critical Incident is an occurrence that requires the provider to make a response that is not a part of the program's ordinary daily routine.

Section 10.6: Critical Incident Reporting

Critical incidents are to be reported to the youth's custodial case manager and the youth's parent or guardian when appropriate.

"Each CIP provider shall develop an internal process for obtaining on-call/emergency contact information for all custodial case managers in the event of an emergency or critical incident."

The following critical incidents should be verbally reported immediately with a written report to the custodial case manager within 24 hours of the event (please refer to the following definitions for clarification):

- **Attempted suicide**: The attempt to intentionally kill oneself and the attempt caused injury or could have resulted in serious injury or death if not detected.
- **Suicide**: Intentionally killing oneself.
- **Homicide**: The killing of one person by another.
- **Other death**: Accidental death or death from natural causes of youth.
- **Assault/Battery**: Verbally creating fear of bodily harm and/or the causing bodily harm against another person.
- **Sexual misconduct**: Any sexual conduct between youth or between youth and staff/volunteers. Sexual conduct includes the intentional touching of another person's intimate parts, or the clothing covering the immediate area of the intimate parts, committed with sexual or aggressive intent.
- **Alleged maltreatment of youth**: Any act or situation of abuse and/or neglect, as defined by K.A.R. 30-46-10.
- **Serious youth injury/illness**: Any youth illness that requires the youth to be hospitalized or receive significant medical treatment. Significant medical treatment is treatment that could not be handled by a trained health care person outside of the hospital or clinical setting.
- **Serious infectious disease**: Diseases such as, but not limited to TB, Hepatitis A/B/C, or a serious sexually transmitted disease as tracked by the Center for Disease Control (CDC). This only needs to be reported if there is a threat of transmission of the disease to staff or other youth.
- **Riot/Hostage situation**: Any disturbance by three or more youth that seriously disturbs the operation of a facility, jeopardizes the control of an area, threatens violence against or destruction of property, or results in significant property damage or personal injury to youth or staff. Includes any hostage situation.
- **Natural disaster**: Acts of nature which cause personal injury to staff and/or youth or which causes structural damage to the physical structure housing youth.
- **AWOL**: A youth's departure from a placement or supervision without lawful authority, as defined by K.S.A. 75-712f. This also includes youth while on a supervised off grounds setting (i.e. transports, hospital, and medical visits). Reported verbally to law enforcement and the custodial case manager immediately with a written report to the custodial case manager within 24 hours of the event. An immediate verbal notification is to be made to law enforcement and to the custodial case manager when the youth returns or is located.
- **Other**: Any action or situation which would require a response by law enforcement, the fire department, an ambulance or another emergency response provider. Incidents in this category would also include any incident not reported in another category and have the potential for significant media coverage.

If the critical incident involves abuse or neglect, the facility must also follow mandated reporting requirements.

All facilities must have procedures for reporting critical incidents to administrative staff and recording critical incidents in the resident files. An administrative file of critical incidents must be kept by facility.

An administrative file shall be kept by the facility documenting critical incidents that is separate from the documentation in the youth's file.

DETENTION STANDARDS

4.1 DETENTION

Standards and Guidelines

Definition

A detention center is a physically secure, restrictive facility designed for alleged or adjudicated youth (10-18 years) who require a secure temporary facility.

Documentation

- Detention center license
- Court order detaining youth as per K.S.A. 38-1640
- Placement Agreement
- Case logs
- Written critical incident reports
- Health records
- Social service plans
- Personnel records
- In-service training and consultation hours for staff
- Time sheets
- Written quarterly reports
- Discharge summary

Minimum Qualifications

Licensure by the Kansas Department of Health and Environment as a detention center.

Duties

- Situational training
- Daily living services
- Situational counseling
- School/work liaison
- Service coordination
- Establishment and monitoring of treatment goals
- Appropriate educational plan
- Tutoring
- Transportation for court appearance, medical, psychiatric appointments

Abuse/Neglect Reporting:

Physical Abuse means the infliction of physical harm on a child or the causation of a child's deterioration, or the likelihood of harm or deterioration. K.A.R. 30-46-10

Sexual Abuse means any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include allowing, permitting, or encouraging a child to engage in prostitution or to be photographed, filmed, or depicted in obscene or pornographic material. Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity, or coercion. K.A.R. 30-46-10

Mental or Emotional Abuse means the infliction of mental or emotional harm to a child or the causation of a child's deterioration. This term may include, but shall not be limited to, maltreatment or exploitation of a child to the extent the child's health is likely to be harmed.

This term may include the following:

1. terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;
2. emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child;
3. corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behaviors. K.A.R. 30-46-10

Neglect means any act or omission by a parent, guardian or person responsible for the care of a child resulting in harm to a child or presenting a likelihood of harm and the acts or omissions are not due solely to the lack of financial means of a child's parent or other custodian. Neglect may include but, shall not be limited to:

1. failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;
2. failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or the likelihood of harm to the child; or
3. failure to use resources available to treat a diagnosed medical condition if the treatment will make the child substantially more comfortable, reduce pain and suffering, correct or substantially diminish a crippling condition, or prevent the condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202(t).

Mandated Reporters:

Mandated reporters must report all witnessed or suspected abuse/neglect to SRS through the SRS Kansas Abuse/Neglect Hotline.

K.S.A. 38-2223 states that when any of the following persons has reason to suspect that a child has been harmed as a result of physical, mental or emotional abuse or neglect or sexual abuse, the person shall report the matter promptly:

A. The following persons providing medical care or treatment: Persons licensed to practice the healing arts, dentistry and optometry; persons engaged in postgraduate training programs approved by the state board of healing arts; licensed professional or practical nurses; and chief administrative officers of medical care facilities;

B. The following persons licensed by the state to provide mental health services: Licensed psychologists, licensed masters level psychologists, licensed clinical psychotherapists, licensed social workers, licensed marriage and family therapists, licensed clinical marriage and family therapists, licensed professional counselors, licensed clinical professional counselors and registered alcohol and drug abuse counselors;

C. Teachers, school administrators or other employees of an educational institution which the child is attending and persons licensed by the secretary of health and environment to provide child care services or the employees of persons so licensed at the place where the child care services are

being provided to the child; and

D. Firefighters, emergency medical services personnel, law enforcement officers, juvenile intake and assessment workers, court services officers and community corrections officers, case managers appointed under K.S.A. 23-1001 et seq., and amendments thereto, and mediators appointed under K.S.A. 23-602, and amendments thereto.

Abuse/neglect reported or witnessed in any Detention center must be immediately reported to the youth's custodial case manager and SRS through the SRS Kansas Abuse/Neglect Hotline (1-800-922-5330). The Abuse/Neglect Hotline number must be posted in a prominent place in the facility. Any employee of the facility who witnesses or hears about the abuse/neglect of a resident within that facility is to notify the Director of the facility immediately, except in cases where the alleged perpetrator is the facility Director. The facility Director is responsible to see to it that all cases of abuse/neglect are reported to them and are passed on to the resident's custodial case manager and SRS through the SRS Kansas Abuse/Neglect Hotline. At no time shall the administration of a program in which abuse/neglect has allegedly occurred interfere or otherwise attempt to alter the report of an abuse/neglect claim made by an employee of that facility.

Critical Incident:

A Critical Incident is an occurrence that requires the provider to make a response that is not a part of the program's ordinary daily routine.

Critical Incident Reporting:

Critical incidents are to be reported to the youth's custodial case manager and the youth's parent or guardian when appropriate.

"Each facility shall develop an internal process for obtaining on-call/emergency contact information for all custodial case managers in the event of an emergency or critical incident."

The following critical incidents should be verbally reported immediately with a written report to the custodial case manager within 24 hours of the event (please refer to the following definitions for clarification):

- **Attempted suicide**: The attempt to intentionally kill oneself and the attempt caused injury or could have resulted in serious injury or death if not detected.
- **Suicide**: Intentionally killing oneself.
- **Homicide**: The killing of one person by another.
- **Other death**: Accidental death or death from natural causes of youth.
- **Assault/Battery**: Verbally creating fear of bodily harm and/or the causing bodily harm against another person.
- **Sexual misconduct**: Any sexual conduct between youth or between youth and staff/volunteers. Sexual conduct includes the intentional touching of another person's intimate parts, or the clothing covering the immediate area of the intimate parts, committed with sexual or aggressive intent.
- **Alleged maltreatment of youth**: Any act or situation of abuse and/or neglect, as defined by K.A.R. 30-46-10.
- **Serious youth injury/illness**: Any youth illness that requires the youth to be hospitalized or receive significant medical treatment. Significant medical treatment is treatment that could not be handled by a trained health care person outside of the hospital or clinical setting.
- **Serious infectious disease**: Diseases such as, but not limited to TB, Hepatitis A/B/C, or a serious sexually transmitted disease as tracked by the Center for Disease Control (CDC). This only needs

to be reported if there is a threat of transmission of the disease to staff or other youth.

- **Riot/Hostage situation**: Any disturbance by three or more youth that seriously disturbs the operation of a facility, jeopardizes the control of an area, threatens violence against or destruction of property, or results in significant property damage or personal injury to youth or staff. Includes any hostage situation.
- **Natural disaster**: Acts of nature which cause personal injury to staff and/or youth or which causes structural damage to the physical structure housing youth.
- **AWOL**: A youth's departure from a placement or supervision without lawful authority, as defined by K.S.A. 75-712f. This also includes youth while on a supervised off grounds setting (i.e. transports, hospital, and medical visits). Reported verbally to law enforcement and the custodial case manager immediately with a written report to the custodial case manager within 24 hours of the event. An immediate verbal notification is to be made to law enforcement and to the custodial case manager when the youth returns or is located.
- **Other**: Any action or situation which would require a response by law enforcement, the fire department, an ambulance or another emergency response provider. Incidents in this category would also include any incident not reported in another category and have the potential for significant media coverage.

If the critical incident involves abuse or neglect, the facility must also follow mandated reporting requirements.

All facilities must have procedures for reporting critical incidents to administrative staff and recording critical incidents in the resident files. An administrative file of critical incidents must be kept by facility.

An administrative file shall be kept by the facility documenting critical incidents that is separate from the documentation in the youth's file.

Expected Outcomes

- One hundred percent (100%) of youth maintained in a secure setting safely.
- Ninety eight percent (98%) of youth maintained will have no confirmed abuse.
- Ninety eight percent (98%) of youth maintained will not experience a runaway.
- Ninety eight percent (98%) of youth maintained will not have an unexcused absence from their education facility.

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Psychiatric Residential Treatment Facility
Service Standards Manual Volume 2
Effective: September 1, 2009

Department of Social and Rehabilitation Services

Overview

The purpose of these standards is to define the minimum programmatic requirements that must be met by any organization approved or seeking SRS approval as a psychiatric residential treatment facility (PRTF).

A PRTF provides comprehensive mental health treatment to children and adolescents (youth) who, due to mental illness, substance abuse, or severe emotional disturbance, are in need of treatment that can most effectively be provided in a psychiatric residential treatment facility. All other ambulatory care resources available in the community have been identified, and if not accessed, determined to not meet the immediate treatment needs of the youth. PRTF programs are designed to offer a short term, intense, focused mental health treatment program to promote a successful return of the youth to the community. Specific outcomes of the mental health services include the youth returning to the youth's family or to another less restrictive community living situation as soon as clinically possible and when treatment in a PRTF is no longer medically necessary. The residential treatment facility is expected to work actively with the family, other agencies, and the community to offer strengths-based, culturally competent, medically appropriate treatment designed to meet the individual needs of the youth including those identified with emotional and behavioral issues.

The following Center for Medicaid Services (CMS) regulations were considered critical in developing the attached set of draft regulations for psychiatric residential facilities: 42 CFR §441.151 through §441.182 of Subpart D of the Federal code.

DEFINITIONS

Absent day: If a resident is not at the facility at the evening census taken at 11:59 pm the resident is considered absent for that day. Therefore, the PRTF may not bill for that day unless the absence has been pre-approved as outlined and within the limits of the State's absentee (reserve day) policy.

CBST (Community-Based Service Team): an individualized team established to access and integrate community resources to meet the youth's mental health needs in the least restrictive environment. The CBST is comprised of the resident (as appropriate), a responsible family member/guardian, a knowledgeable representative from the Community Mental Health Center (CMHC), other clinicians, the custodial case manager, and any other individuals considered to be helpful in determining how to best help the youth.

Centers for Medicare and Medicaid Services (CMS): is the agency of the Federal Department of Health and Human Services responsible for the administration of the Medicaid program.

Certification/Recertification of need: is the assessment and documentation that certifies medical necessity for psychiatric residential treatment services. (See 42 C.F.R.441.152)

Direct Care Staff All direct care staff must meet the following requirements: Be 21 years of age or older and at least three years older than the oldest resident and have a high school diploma or its equivalent. Direct care staff are appropriately trained and responsible for basic interactive care such as supervision, daily living care and mentoring of the residents and assisting in the implementation of the plan of care that is within their scope of practice.

Emergency safety intervention: means the use of restraint or seclusion as an immediate response to an emergency safety situation.

Emergency safety situation: means unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and calls for an emergency safety intervention (restraint or seclusion) as defined in this section.

Executive Director or Facility Administrator: The person responsible for the administrative operations of the facility shall be a full-time staff person with a minimum of a Baccalaureate Degree, at least 3-year administrative experience.

Family: Legally recognized birth, adoptive or foster parents, grandparents, siblings, other relatives, and legal custodians.

Hospital Leave: is an absence from the facility for more than 24 consecutive hours due to the resident receiving acute inpatient treatment in a hospital, including treatment in a psychiatric unit of a hospital, or a state psychiatric hospital. If the PRTF is unable to plan for return of the resident and continue continuity of care planning because it is unsure when the resident may return from the hospital the resident should be discharged. Under no circumstances shall the PRTF bill for more than five resident days when the resident is in the hospital.

Licensed Mental Health Professional (LMHP): is an individual who is licensed in the State of Kansas to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license. A LMHP includes individuals licensed to practice independently, such as: Licensed Psychologists, Licensed Clinical Marriage and Family Therapists, Licensed Clinical Professional Counselors, Licensed Specialist Clinical Social Workers, or Licensed Clinical Psychotherapists.

A LMHP also includes individuals licensed to practice under supervision or direction, such as: Licensed Marriage and Family Therapists, Licensed Professional Counselors, Licensed Masters Social Workers, or Licensed Masters Level Psychologists. Supervision or direction must be provided by a person who is eligible to provide Medicaid services and who is licensed at the clinical level or is a physician.

Mechanical restraint: means any device attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.

Medical Mechanical restraint: Mechanical interventions ordered by a physician used for the assistance of healing or stabilization of physical health.

Medical necessity criteria of a PRTF:

- A substantial risk of harm to self or others, or a child who is so unable to care for his or her own physical health and safety as to create a danger to their life; and
- The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed; and
- All other ambulatory care resources available in the community have been identified and if not accessed, determined to not meet the immediate treatment needs of the youth.

Personal restraint: means the application of physical force without the use of any device, for the purposes of restraining the free movement of a resident's body. The term personal restraint does not include briefly holding without undue force a resident in order to calm or comfort him or her, or holding a resident's hand to safely escort a resident from one area to another.

PRTF Liaison: a designated representative of the responsible community mental health center who collaborates with the PRTF and treatment team to assist with treatment, crisis, and discharge planning.

Psychiatric Residential Treatment Facility (PRTF): is a facility that provides comprehensive inpatient mental health treatment and/or substance abuse services for residents with severe emotional disturbances, substance abuse, and or mental illness that meets State and Federal participation requirements, and is accredited by one of the following accrediting organizations:

1. Council on Accreditation of Rehabilitation Facilities (CARF);
2. Council on Accreditation of Services for Families and Children (COA);
3. The Joint Commission or;
4. an accrediting body approved by the Kansas Health Policy Authority (KHPA), Kansas Department of Social and Rehabilitation Services (SRS) and the Kansas Juvenile Justice Authority (JJA), and
5. is licensed by the Department of Health and Environment and certified to participate in Medicaid reimbursement by the Department of Social and Rehabilitation Services.

Resident: Any child or youth age six to twenty-two years old**,** accepted for care and treatment in a PRTF.

Restraint: means a ``personal restraint," ``mechanical restraint," or ``drug used as a restraint" as defined in this section and under 483.356.

Seclusion: means the involuntary confinement of a resident in an area from which the resident is physically prevented from leaving.

Serious occurrence: means any significant incident or an impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, death, suicide attempts, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

Staff: means those individuals with responsibility for managing a resident's health, safety and well-being, and who are employed by the facility on a full-time, part-time, voluntary or contract basis.

Time out/ self-selected means a brief voluntary time away from activities for a period, for the purpose of providing the resident an opportunity to regain self-control.

Treatment definitions:

- **Active treatment:** means the implementation and supporting documentation of services outlined in a plan of care developed by a treatment team facilitated by the PRTF. It includes assessment, treatment, crisis prevention and discharge planning. Treatment, overseen by a PRTF physician, is designed to achieve the goal of the resident's successful transition back to the community at the earliest possible time. Treatment reviews address and encourage the therapeutic alliance, collaboration on tasks and consensus on goals from staff, resident, resident is family, and community partners.

- **Individual plan of care:** is the written plan of care developed specifically to address the needs of each resident to improve his/her condition to the extent that inpatient care is no longer indicated. (See 42 C.F.R. 441.155).

- **Treatment team:** as described by federal regulations and state standards is responsible for developing and reviewing the individual plan of care and is comprised of PRTF service providers, resident, resident's family, Community Mental Health Center representative (CMHC) as designated liaison and other community partners The PRTF service provider facilitates the treatment and treatment team.

Volunteer staff: means those individuals who are unpaid by the facility to augment the services provided by the staff. Volunteer staff must be 21 years of age or older and at least three years older than the oldest resident.

PROGRAM DESCRIPTION STANDARDS

A. A written program description must guide the agency's operations and delivery of services. Each PRTF is required to develop its own policies, procedures and program description to implement the requirements in this document. The program description must be on file for review by any federal or state agency and the facilities accrediting body during site visits and must be submitted annually on January 1 of each year to the Department of Social and Rehabilitation Services and the Juvenile Justice Authority.

B. The program description will include the facility location, legal ownership, an Administration table of organization, the philosophy, vision and mission of the program and explain in detail how the facility will meet the requirements in this document. The description will include detail regarding the population served by the PRTF, including the number of residents served, age groups, and other relevant characteristics of the population. (This information can be located in different documents and kept together in a file to be readily accessible during any site visit.)

C. If providing substance abuse treatment services on site, the PRTF must be licensed by Addiction and Prevention Services (AAPS) to provide said services employing AAPS certified substance abuse counselors. If sub-contracting substance abuse treatment services, the provider used must be AAPS certified to do so. The activities included in the service must be intended to achieve identified plan of care goals or objectives and be designed to achieve the resident's discharge from inpatient status at the earliest possible time. Services provided must be in accordance with 42CFR 441.154-441.156

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FEDERAL REGULATIONS AND STATE STANDARDS

This document contains language that is Federal Regulation and state standards. Federal language is in normal text. Language that is specific to Kansas PRTF's are in *italics* directly under that particular Federal Regulation. The additional requirement section is specific to state standards.

42 CFR §441 Subpart D—Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs

§441.151 General requirements.

(a) Inpatient psychiatric services for individuals under age 21 must be:

(1) Provided under the direction of a physician;

(2) Provided by—

(i) A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

(ii) A psychiatric facility that is not a hospital and is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the State.

(3) Provided before the individual reaches age 21, or, if the individual was receiving the services immediately before he or she reached age 21, before the earlier of the following—

(i) The date the individual no longer requires the services; or

(ii) The date the individual reaches 22; and

(4) Certified in writing to be necessary in the setting in which the services will be provided (or are being provided in emergency circumstances) in accordance with §441.152.

(b) Inpatient psychiatric services furnished in a psychiatric residential treatment facility as defined in §483.352 of this chapter must satisfy all requirements in subpart G of part 483 of this chapter governing the use of restraint and seclusion.

[66 FR 7160, Jan. 22, 2001]

(1) Referenced above: Under the direction of a physician means: Under the direction of a physician licensed and board eligible or board certified in the state where the PRTF is located. These physicians may be employed by or under contract with the PRTF.

The physician must provide for the clinical oversight of all services provided by the PRTF.
A physician who is licensed and board eligible or a board certified psychiatrist (or a physician who is not a psychiatrist BUT is working in conjunction with a psychologist consistent with 441.156) must be available to oversee the medical needs of the resident including medication management, plan of care development, and can order seclusion and restraint consistent with CFR 42 subpart G of part 483.

§441.152 Certification of need for services.

(a) A team specified in §441.154 must certify that—

(1) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;

(2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

(b) The certification specified in this section and in §441.153 satisfies the utilization control requirement for physician certification in §§456.60, 456.160, and 456.360 of this subchapter.

[43 FR 45229, Sept. 29, 1978, as amended at 61 FR 38398, July 24, 1996]

(a) Referenced above: Certification and recertification of the need for services is defined in the Kansas definitions section of this document. The LMHP certifying and re-certifying the need for services must be independent of the facility.

§441.153 Team certifying need for services.
Certification under §441.152 must be made by terms specified as follows:
(a) For an individual who is a recipient when admitted to a facility or program, certification must be made by an independent team that—
(1) Includes a physician;
(2) Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and
(3) Has knowledge of the individual's situation.
(b) For an individual who applies for Medicaid while in the facility of program, the certification must be—
(1) Made by the team responsible for the plan of care as specified in §441.156; and
(2) Cover any period before application for which claims are made.
(c) For emergency admissions, the certification must be made by the team responsible for the plan of care (§441.156) within 14 days after admission.

(a)(1) Referenced above: The team responsible for the certification and recertification of services will be the LMHP certifier in conjunction with the Community-Based Services Team (CBST). This must include a face-to-face assessment by an independent LMHP. Recertification must occur within 90 days of admission and within every 60 days thereafter.

§441.154 Active treatment
Inpatient psychiatric services must involve "active treatment", which means implementation of a professionally developed and supervised individual plan of care, described in §441.155 that is—
(a) Developed and implemented no later than 14 days after admission; and
(b) Designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

Active treatment will begin immediately upon admission with the information provided by the LMHP doing the certification of need, CBST recommendations and assessments performed by the PRTF. This forms the basis for establishing the immediate plan of care and criteria for discharge.

Active treatment includes ongoing family involvement in the planning for and delivery of services. In active treatment, programming is individualized to the needs of each resident and the family to maximize individual functioning in activities of daily living, education, and vocational preparation.

The PRTF is expected to appropriately treat a resident, document the delivery and response to treatment, and provide or obtain all services the resident needs while a resident of the facility. Services provided by the PRTF must be built on the competencies of the resident and the family, while addressing specific needs (e.g., culture, treatment history, family relationships, etc.) It is expected that therapeutic services are provided at a time that is conducive for the involvement of the youth and family. Specific expectations include, at a minimum, the following, all of which must be provided as needed and documented in the resident's record:

During all waking hours including evenings and weekends, residents of the PRTF shall be engaged in active treatment, this includes:
Engagement services and activities, including the following:

- *Engaging the resident in a purposeful, supportive, and helping relationship;*

- *Eliciting the residents and resident's family choices concerning basic needs, including determining what supports the resident needs, what productive activities the resident desires to engage in, and what leisure activities the resident desires to participate in; and*
- *Understanding the residents personal history and either satisfaction or dissatisfaction with services and treatments, including medications, that have been provided to or prescribed in the past.*

Strengths assessment services and activities, including the following:

- *Identifying and assessing the residents wants and needs, the residents aspirations for the future, the resources that are or might be available to that resident and their family, the sources of motivation available to the resident, and the strengths and capabilities the resident possesses;*
- *Identifying and researching what educational and vocational, and social resources are or might be available to the resident and might facilitate that resident's treatment, and*
- *Identifying, researching, and understanding the cultural factors that might have affected or that might affect the residents experience with receiving treatment and other services, the effects that these factors might have on the treatment process, and the ways in which these factors might be best used to support the resident's treatment.*

Goal-planning services and activities, including the following:

- *Helping the resident to identify, organize, and prioritize the resident and resident's family's personal goals and objectives with regard to treatment, education and training, and community involvement;*
- *Assisting and supporting the resident in choosing and pursuing activities consistent with achieving those goals and objectives at a pace consistent with that residents capabilities, and motivation;*
- *Teaching the resident goal-setting and problem-solving skills independent living skills, social, and self management skills;*
- *Identifying critical stressors that negatively affect the resident's mental status and those interventions, coping strategies, and supportive resources that have been successful or helpful in addressing or relieving those stressors in the past; and*
- *Develop relapse prevention strategies, including wrap-around plans and advance directives, which the resident may utilize;*

Advocacy services and activities, including the following:

- *Coordinating the treatment and supportive efforts for the resident.*
- *Advocating for the resident, as appropriate, in developing goals and objectives within the residents individualized plan of care during the course of that residents treatment, and assisting in acquiring the resources necessary for achieving those goals and objectives*

§441.155 Individual plan of care.

(a) "Individual plan of care" means a written plan developed for each recipient in accordance with §§456.180 and 456.181 of this chapter, to improve his condition to the extent that inpatient care is no longer necessary.

(b) The plan of care must—

(1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care;

(2) Be developed by a team of professionals specified under §441.156 in consultation with the recipient; and his parents, legal guardians, or others in whose care he will be released after discharge;

(3) State treatment objectives;

(4) Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and

(5) Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school, and community upon discharge.

(c) The plan must be reviewed every 30 days by the team specified in §441.156 to—

(1) Determine that services being provided are or were required on an inpatient basis, and

(2) Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.

(d) The development and review of the plan of care as specified in this section satisfies the utilization control requirements for—

(1) Recertification under §§456.60(b), 456.160(b), and 456.360(b) of this subchapter; and

(2) Establishment and periodic review of the plan of care under §§456.80, 456.180, and 456.380 of this subchapter.

[43 FR 45229, Sept. 29, 1978, as amended at 46 FR 48560, Oct. 1, 1981; 61 FR 38398, July 24, 1996]

(a)Referenced above: Each resident must have a written individual plan of care, which is goal-oriented and specific, describing the services to be provided.

(b) Referenced above: The plan of care should;

(1)Include strengths and preferences and address any other needs which have been identified, including the assessment of trauma and family resources and be implemented no later than 14 days after admission, or 24 hours after returning from an inpatient hospitalization or unexcused leave of absence from the facility (See 42C.F.R.441.154)

(2) Be based upon input from the Community Based Services Team and community treatment team to which the youth will be discharged.

(3) Be related to overall treatment goals that address the residents immediate and long range therapeutic needs

(4) Includes criteria and plan for post discharge which is updated at each of the 30 day reviews

a. Discharge planning for the residents shall begin as soon as possible upon admission to the PRTF. This process should include the CMHC staff where the youth will be discharging to if determined, the treatment team and other facility staff, and the resident and their legal guardian when possible. The CMHC and the legal guardian should remain in contact with the facility treatment team to assist in any transition discharge planning. Discharge criteria will be established when writing the plan of care

b. Prior to discharge, the PRTF shall submit documents related to the residents care in their facility to any mental health provider who will be providing aftercare. The key component on this document shall include:

- *Medical needs including allergies*
- *Medication; dosage; clinical rationale; prescriber*
- *Discharge diagnosis*
- *Prevention plan to address symptoms of harm to self or others*
- *Any other essential recommendations*
- *Appointments with after discharge service providers-date, time, place*
- *Contact information for internal providers*
- *Contact information for CMHC/PRTF Liaisons*
- *CMHC Crisis line number*
- *Education contact number from PRTF*

c. For any resident receiving or who has received psychotropic medication during their stay the clinical rational for each medication shall be clearly documented on their psychiatric discharge summary or final evaluation. The reason for discharge will also be clearly stated on the discharge summary. Residents on psychotropic medication must leave the facility with a prescription written for at least a 30-day supply of medication. The residents should also leave the facility with a minimum of three-day's worth of prescriptions when applicable. The expectation is that the

PRTF will receive notification ten days before the child must leave the PRTF to ensure proper discharge planning. If the discharge must occur prior to a ten-day notification, it is the PRTF's responsibility in conjunction with the custodial case manager or community case manager to ensure proper persons are notified of the residents pending discharge, including discharge date and assisting with appointment setting in the community. The PRTF must ensure proper identification of individuals who pick up the resident upon discharge.

(c) Referenced above: The treatment team must review the plan of care within thirty days and subsequent reviews within 30 days thereafter, evidenced through documentation which meets state and federal requirements. The plan of care and subsequent reviews support the continued need for PRTF services and is evidenced by the participation of the resident and, if appropriate, one or more members of the resident's family as well as clinical signatures.

§441.156 Team developing individual plan of care.

(a) The individual plan of care under §441.155 must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in, the facility.

(b) Based on education and experience, preferably including competence in child psychiatry, the team must be capable of—

(1) Assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

(2) Assessing the potential resources of the recipient's family;

(3) Setting treatment objectives; and

(4) Prescribing therapeutic modalities to achieve the plan's objectives.

(c) The team must include, as a minimum, either—

(1) A Board-eligible or Board-certified psychiatrist;

(2) A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

(3) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

(d) The team must also include one of the following:

(1) A psychiatric social worker.

(2) A registered nurse with specialized training or one year's experience in treating mentally ill individuals.

(3) An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals.

(4) A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

(a) Referenced above: The treatment team must include the resident, resident's family, and the Community Mental Health Center (CMHC) representative or designated liaison and LMHP.

c(3) Referenced above: Certification by the state means licensed by the state.

§ 483.356 Protection of residents.

(a) Restraint and seclusion policy for the protection of residents.

(1) Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.

(2) An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.

(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only—

(i) To ensure the safety of the resident or others during an emergency safety situation; and

(ii) Until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.

(4) Restraint and seclusion must not be used simultaneously.

(b) Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).

(c) Notification of facility policy. At admission, the facility must—

(1) Inform both the incoming resident and, in the case of a minor, the resident's parent(s) or legal guardian(s) of the facility's policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the resident is in the program;

(2) Communicate its restraint and seclusion policy in a language that the resident, or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, the facility must provide interpreters or translators;

(3) Obtain an acknowledgment, in writing, from the resident, or in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgment in the resident's record; and

(4) Provide a copy of the facility policy to the resident and in the case of a minor, to the resident's parent(s) or legal guardian(s).

(d) Contact information. The facility's policy must provide contact information, including the phone number and mailing address, for the appropriate State Protection and Advocacy organization.

(a) (1) Referenced above: Any type of mechanical device shall not be used as a restraint unless it meets the definition of medical mechanical restraint.

The use of restraint or seclusion should be selected only when other less restrictive measures have been found to be ineffective to protect the resident or others. The facility shall demonstrate effective treatment approaches and alternatives to the use of restraint and/or seclusion. Active treatment does not include the routine use of restraint and seclusion.

A written plan to address the limited use of restraint and/or seclusion shall be developed by the PRTF and be available at the request of the Department of Social and Rehabilitation Services, Kansas Department of Health and Environment, Juvenile Justice Authority, or the Kansas Health Policy Authority.

(a)(2) Referenced above: Practices must be consistent with CMS interpretive guidelines, therefore the following language has been adopted.
The use of restraint (includes drugs used as a restraint) or seclusion must not be a planned or anticipated intervention. In order to ensure a resident receives active treatment and is free from abuse, it is necessary that an order be given for each instance of restraint or seclusion.

After all less restrictive measures have been attempted to end the emergency safety situation, a resident must be assessed by a physician, or other licensed practitioner permitted by the state to order restraint or seclusion, who will then give a one-time order for that specific resident in that particular emergency

safety situation. Once that order has expired, it may not be renewed on a planned, anticipated, or as-needed basis.

Drugs or medication used for standard treatment of the resident's medical or psychiatric condition shall not be considered a restraint. Standard treatment for the resident's medical condition shall mean the following.

- *Medication is used within the pharmaceutical parameters approved by the FDA and the Manufacturer for the indications it is manufactured and labeled to address, including listed dosage parameters.*
- *The use of the medication follows national practice standards established or recognized by the medical community and/or professional medical association or organization*
- *The use of medication to treat a specific resident's clinical condition is based on the residents symptoms, overall clinical situation, and on the physician's or other Independent Licensed Practitioner's knowledge of the resident's expected and actual response to the medication.*
- *The standard use of a medication to treat the resident's condition enables the resident to more effectively or appropriately function in the world around them than would be possible without the use of the medication. If the overall effect of a medication is to reduce the residents ability to effectively or appropriately interact with the world around the resident, then the medication is not being used as a standard treatment for the resident's condition*

The use of psychopharmacological medication used in excess of the resident's standard plan of care should be considered a restraint. This includes:

- *Drugs or medications used to control behavior or restrict the individual's freedom of movement*
- *Drugs or medications used in excessive amounts or in excessive frequency*
- *Neuroleptics, anxiolytics, antihistamines, and atypical neuroloptics, or other medications used for calming rather than for the medication's indicated treatment*
    - *All rules, regulations, and guidelines governing the use of restraints apply when these drugs are used as a restraint*

(d) Referenced above: The Kansas State Protection and Advocacy Organization is the Disability Rights Center of Kansas (DRC). Formerly known as the Kansas Advocacy & Protective Services (KAPS).
Disability Rights Center of Kansas (DRC)
635 S.W. Harrison Street, Suite 100
Topeka, Kansas 66603-3726
Voice: 785-273-9661
Toll free Voice: 1-877-776-1541
Toll free TDD: 1-877-335-3725
Fax: 785-273-9414

§ 483.358 Orders for the use of restraint or seclusion.

(a) Orders for restraint or seclusion must be by a physician, or other licensed practitioner permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for recipients under age 21 be provided under the direction of a physician.

(b) If the resident's treatment team physician is available, only he or she can order restraint or seclusion.

(c) A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.

(d) If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed written form in the resident's record. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

(e) Each order for restraint or seclusion must:

(1) Be limited to no longer than the duration of the emergency safety situation; and

(2) Under no circumstances exceed 4 hours for residents ages 18 to 21; 2 hours for residents ages 9 to 17; or 1 hour for residents under age 9.

(f) Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well being of residents, must conduct a face-to-face assessment of the physical and psychological well being of the resident, including but not limited to—

(1) The resident's physical and psychological status;

(2) The residents' behavior;

(3) The appropriateness of the intervention measures; and

(4) Any complications resulting from the intervention.

(g) Each order for restraint or seclusion must include—

(1) The name of the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion;

(2) The date and time the order was obtained; and

(3) The emergency safety intervention ordered, including the length of time for which the physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion authorized its use.

(h) Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

(1) Each order for restraint or seclusion as required in paragraph (g) of this section.

(2) The time the emergency safety intervention actually began and ended.

(3) The time and results of the 1-hour assessment required in paragraph (f) of this section.

(4) The emergency safety situation that required the resident to be restrained or put in seclusion.

(5) The name of staff involved in the emergency safety intervention.

(i) The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes.

(j) The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible.

[66 FR 7161, Jan. 22, 2001, as amended at 66 FR 28116, May 22, 2001]

(a) *Referenced above: Other than a physician, the only licensed practitioner permitted by the state to order seclusion or restraint is a physician's assistant (PA) working under protocol, or an advanced registered nurse practitioner (ARNP) working under protocol, a PhD psychologist, or the head of the treatment facility or their designee who must be a physician, PA, ARNP, or a LMHP as defined in the definitions section of this document and the state Medicaid Plan.*

(c) Referenced above: See the definition of licensed practitioner permitted by the State in (a) above.

(d) Referenced above: Licensed staff means licensed health care professionals who are operating within the scope of their practice and capable of receiving orders. Trained RNs and LPN's are appropriate. The physician, ARNP, PA, or LMHP giving the order for the restraint or seclusion must also be available throughout the use of the emergency safety intervention.

(e)(2) Referenced above: Emergency safety interventions may not exceed 4 hours for residents ages 18 to 21; 2 hour for residents ages 9 to 17; or 1 hour for residents under age 9. Throughout the use of the emergency safety intervention staff should be assessing, monitoring, and re-evaluating the resident so that he or she is released from the restraint or seclusion at the earliest possible time.

(f) Referenced above: A licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess psychological and physical well being of residents within 1 hour of the initiation of the emergency safety intervention. A physician, a physician's assistant (PA), an advanced registered nurse practitioner (ARNP) or a trained registered nurse (RN) are qualified to assess physical wellbeing.

(h) (i) Referenced above: The name and credentials of staff involved in the restraint.

(j) Referenced above: Consultation with treatment team physician

§ 483.360 Consultation with treatment team physician.
If a physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion orders the use of restraint or seclusion, that person must contact the resident's treatment team physician, unless the ordering physician is in fact the resident's treatment team physician. The person ordering the use of restraint or seclusion must—

(a) Consult with the resident's treatment team physician as soon as possible and inform the team physician of the emergency safety situation that required the resident to be restrained or placed in seclusion; and

(b) Document in the resident's record the date and time the team physician was consulted.
[66 FR 7161, Jan. 22, 2001, as amended at 66 FR 28117, May 22, 2001]

§ 483.362 Monitoring of the resident in and immediately after restraint.
(a) Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention.

(b) If the emergency safety situation continues beyond the time limit of the order for the use of restraint, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion to receive further instructions.

(c) A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the restraint is removed.
[66 FR 7161, Jan. 22, 2001, as amended at 66 FR 28117, May 22, 2001]

(a) Referenced above: All facility direct care staff must complete an SRS approved training program on the use of emergency safety interventions.

Clinical staff are defined as direct care staff or LMHP's, who have been appropriately trained as described in (a) on the use of emergency safety interventions, and who have been trained how to appropriately monitor residents in seclusion and restraint. Facility policies and procedures should specify who is clinically trained and appropriate to monitor residents in emergency interventions.

(c) Referenced above: Licensed practitioners permitted by the state and the facility to evaluate the residents physical and psychological well-being immediately after a resident is removed from a restraint are physicians, a physician's assistant (PA), an advanced registered nurse practitioner (ARNP),a trained- registered nurse (RN).

§ 483.364 Monitoring of the resident in and immediately after seclusion.
(a) Clinical staff, trained in the use of emergency safety interventions, must be physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the resident in seclusion. Video monitoring does not meet this requirement.

(b) A room used for seclusion must—
(1) Allow staff full view of the resident in all areas of the room; and
(2) Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.

(c) If the emergency safety situation continues beyond the time limit of the order for the use of seclusion, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion to receive further instructions.

(d) A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the resident is removed from seclusion.
[66 FR 7161, Jan. 22, 2001, as amended at 66 FR 28117, May 22, 2001]

(a) Referenced above: All facility direct care staff must complete an SRS approved training program on the use of emergency safety interventions.

Clinical staff is defined as direct care staff or LMHPs, who have been appropriately trained as described in (a) on the use of emergency safety interventions, and who have been trained how to appropriately monitor residents in seclusion and restraint. Facility policies and procedures should specify who is clinically trained and appropriate to monitor residents in emergency interventions.

(d) Referenced above: Licensed practitioners permitted by the state and the facility to evaluate the residents well-being immediately after a resident is removed from a restraint are physicians, a physician's assistant (PA), an advanced registered nurse practitioner (ARNP),and a trained-registered nurse (RN).

§ 483.366 Notification of parent(s) or legal guardian(s).
If the resident is a minor as defined in this subpart:
(a) The facility must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention.

(b) The facility must document in the resident's record that the parent(s) or legal guardian(s) has been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the notification.

§ 483.368 Application of time out.
(a) A resident in time out must never be physically prevented from leaving the time out area.
(b) Time out may take place away from the area of activity or from other residents, such as in the resident's room (exclusionary), or in the area of activity or other residents (inclusionary).
(c) Staff must monitor the resident while he or she is in time out.

(a) Referenced above: if a resident does not stay in time out voluntarily, it is considered seclusion.

§ 483.370 Post-intervention debriefings.
(a) Within 24 hours after the use of restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident's parent(s) or legal guardian(s). The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion.

(b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of—

(1) The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention;
(2) Alternative techniques that might have prevented the use of the restraint or seclusion;
(3) The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and
(4) The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

(c) Staff must document in the resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, names of staff that were excused from the debriefing, and any changes to the residents' plan of care that result from the debriefings.

§ 483.372 Medical treatment for injuries resulting from an emergency safety intervention.
(a) Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention.

(b) The psychiatric residential treatment facility must have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the Medicaid program that reasonably ensure that—

(1) A resident will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;
(2) Medical and other information needed for care of the resident in light of such a transfer, will be exchanged between the institutions in accordance with State medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and
(3) Services are available to each resident 24 hours a day, 7 days a week.

(c) Staff must document in the resident's record, all injuries that occur as a result of an emergency safety intervention, including injuries to staff resulting from that intervention.

(d) Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

(c) Reference above, The resident's family and/or custodial case manager shall be notified as soon as possible adhering to parental preference, no later than 24 hours, of any injuries resulting from an emergency safety intervention.

§ 483.374 Facility reporting.

(a) Attestation of facility compliance. Each psychiatric residential treatment facility that provides inpatient psychiatric services to individuals under age 21 must attest, in writing that the facility is in compliance with CMS's standards governing the use of restraint and seclusion. This attestation must be signed by the facility director.

(1) A facility with a current provider agreement with the Medicaid agency must provide its attestation to the State Medicaid agency by July 21, 2001.

(2) A facility enrolling as a Medicaid provider must meet this requirement at the time it executes a provider agreement with the Medicaid agency.

(b) Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State-designated Protection and Advocacy system. Serious occurrences that must be reported include a resident's death, a serious injury to a resident as defined in §483.352 of this part, and a resident's suicide attempt.

(1) Staff must report any serious occurrence involving a resident to the State Medicaid agency, the State-designated Protection and Advocacy system, and the licensing agency. by no later than close of business the next business day after a serious occurrence. The report must include the name of the resident involved in the serious occurrence, a description of the occurrence, and the name, street address, and telephone number of the facility.

(2) In the case of a minor, the facility must notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence.

(3) Staff must document in the resident's record that the serious occurrence was reported to the State Medicaid agency, the State-designated Protection and Advocacy system, and the licensing agency. This report should include the name of the person to whom the incident was reported. A copy of the report must be maintained in the resident's record, as well as in the incident and accident report logs kept by the facility.

(c) Reporting of deaths. In addition to the reporting requirements contained in paragraph (b) of this section, facilities must report the death of any resident to the Centers for Medicare & Medicaid Services (CMS) regional office.

(1) Staff must report the death of any resident to the CMS regional office by no later than close of business the next business day after the resident's death.

(2) Staff must document in the resident's record that the death was reported to the CMS regional office.

[66 FR 7161, Jan. 22, 2001, as amended at 66 FR 28117, May 22, 2001]

Referenced above (b) all serious injuries defined as any significant impairment of the physical condition of a resident as determined by qualified medical personnel.

i. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematomas, and injuries to internal organs, whether self-inflicted or inflicted by others.

ii. All injuries that require medical intervention beyond first aid, including lacerations requiring stitches, substantial hematomas, as well as all death and all suicide attempts are considered

serious occurrences and must be reported by no later than close of business the next business day after a serious occurrence to the State Medicaid Agency (The Kansas Health policy Authority), Department of Social and Rehabilitation Services Mental Health, applicable child welfare contractor/case manager or JJA case manager, the Kansas Protective Advocacy System/Disability rights center of Kansas and Kansas Department of Health and Environment.

iii. It is the responsibility of the facility to ensure that it reports serious occurrences appropriately.

iv. The facility must investigate any injuries of unknown origin to ensure that a resident is not at risk of additional harm. In addition, if a resident has repeated injuries that are indicative of a pattern, the facility should investigate to ensure that the resident is not subjected to hostile environment also to take steps to minimize the risk of more injuries.

v. In cases of suspected abuse, neglect, or exploitation of a resident, the facility must follow mandated reporting procedures immediately per K.S.A.21-3501 through K.S.A. 21-3503 and amendments thereto.

(b)(2) The resident's family and agency case manager shall be notified of all reportable incidents

(b)(3) The facility will document all notifications and retain a serious occurrence report in the residents file.

The PRTF shall notify SRS/MH of any natural disaster (e.g. fire, flood, etc.), work stoppage, KDHE licensing requirements or any significant event-affecting residents of the facility as soon as possible.

§ 483.376 Education and training.

(a) The facility must require staff to have ongoing education, training, and demonstrated knowledge of—

(1) Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations;

(2) The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and

(3) The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion.

(b) Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.

(c) Individuals who are qualified by education, training, and experience must provide staff training.

(d) Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.

(e) Staff must be trained and demonstrate competency before participating in an emergency safety intervention.

(f) Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis and their competencies as specified in paragraph (b) of this section on an annual basis.

(g) The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.

(h) All training programs and materials used by the facility must be available for review by CMS, the State Medicaid agency, and the State survey agency.

(1) The PRTF shall provide written training plan that meets SRS approval for all staff having direct contact with residents. This training shall include temporary, part-time staff and volunteers, which includes specific training for newly hired staff and for the ongoing competence of all staff, including staff with whom the facility contracts for service. A record of all training must be kept for each staff and volunteer.

(2) Prior to working with residents, all staff shall have an orientation to the persons' specific duties and responsibilities and the policies and procedures of the facility, including reportable incident

reporting, discipline, care and management of children, medication administration, and use of restrictive procedures.

a. Prior to working alone with residents, the director and each full-time, part-time, volunteer and temporary staff person who will have regular and significant direct contact with residents shall be oriented to the policies and procedures of the facility, be familiar with the facilities behavior management system, and have completed a training curriculum approved by the state which includes the following areas:

(i) Mandatory reporting requirements for abuse, neglect and exploitation.

(ii) First aid, Heimlich techniques, cardiopulmonary resuscitation and universal precautions.

(iii) Crisis intervention, behavior management, and suicide prevention.

(iv) Health and other special issues affecting the population.

(v) Establish a zero-tolerance standard for sexual assault and misconduct for all staff.

(vi) Develop and implement standards for sexual assault detection and prevention

UTILIZATION REVIEW (UR)

In accordance with 42 C.F.R. 456 Subpart D relating to Utilization Control of Mental Hospitals, all Medicaid PRTF services shall have procedures that provide for review of each resident's need for the services. For the Utilization Review (UR), each PRTF shall perform on-going evaluations of the necessity and appropriateness of PRTF services for each resident. The UR shall include a review of the appropriateness of the admission, individual plan of care, length of stay and discharge plan.

Each facility shall have in place continuous performance improvement processes that focus on outcomes of care, treatment, and services. These processes shall include those intended to effectively reduce factors that contribute to unanticipated adverse events and/or outcomes.

One or more employees of the SRS/JJA/KDHE may be assigned to provide technical assistance to the PRTF or to assist the PRTF in developing a performance improvement program or other similar responsibilities. Each PRTF shall cooperate with those agencies efforts and with that agencies monitoring of the PRTF ongoing compliance with the requirements of these standards. This cooperation shall include providing that agency with reasonable access to all of the facilities and administrative records of the licensee and to all clinical records and treatment or service activities of the PRTF.

ADDITIONAL STANDARDS

785-1 Documentation/Resident Records:

ALL NOTES MUST BE LEGIBLE AND CORRECTIONS MUST BE MADE SO NOT TO ALTER CONTENT.

Each resident's record shall contain the following:

Personal information, including:

1. The name, sex, admission date, birth date and Social Security Number.
2. The race, height, weight, color of hair, color of eyes and identifying marks.
3. Language or means of communication spoken and understood by the resident and the primary language used by the resident's family, if other than English.
4. The name, address and telephone number of the person to be contacted in the event of an emergency.
5. Health records.
6. Dental, vision, and hearing records.
7. Health and safety assessments.
8. Current and Past Individual Plans of Care.
9. Consent to treatment forms.
10. Admission and placement information.
11. Signed notification of rights, grievance procedures, including the right to notify SRS and applicable consent to treatment protections.
12. Education records.
13. Past plan of cares.
14. Current and past PRTF psychiatric evaluations.
15. Special consultations or assessments completed or requested as applicable.
16. Copies of Certification and Re-Certification of need.
17. Progress notes that document the resident's participation in individual therapy, group therapy, family therapy, and other therapeutic interventions.
18. Progress notes must include summaries of individual plan of care reviews and special consultations regarding all aspects of the resident's complete daily program.
19. Documentation of the resident's progress toward meeting treatment goals.
20. Documentation of the family's participation in the treatment and discharge planning including copies provided to guardians
21. Documentation of community service providers' participation in the treatment and discharge planning.
22. All medications and regular medication reviews. Clinical rationale shall be clearly documented for each medication. All changes in medication must be documented in the medication orders. Records documenting administration of all medications indicating dosage, actual administration of the medication, responsible staff administering, and signature of the responsible staff person.
23. Documentation of outcomes and reviews following therapeutic leave.
24. Relevant records from other agencies and systems.

785-2 Clinical Documentation:

(a) The following must be included in the resident's clinical record:

(1). Extent of the resident history and exam must be documented along with a comprehensive plan of care and subsequent reviews. Individual plans of care must follow an SRS approved format.

(2). Progress note for every goal directed service provided which shall include:

(i) Date, time, and description of each service delivered and by who (name, designation of profession or Para profession).

(ii) Identification of goals addressed, interventions used and resident's response to service.

(iii) Progress on stated goals

(3). Documentation to support plan of care reviews and discharge planning.

(4). Documentation supporting "special" consultations or clinical supervision, which applies directly to the identified resident.

(5). Documentation of the family's / legal guardian's participation in the planning and treatment.

(6). Documentation indicating regular medication reviews including the current and past psychotropic medications. Clinical rational for each medication shall be clearly documented. All changes in medication must be documented in the medication orders. Records documenting administration of all prescribed medications indicating dosage, actual administration of medication, responsible staff administering, and signature of responsible staff person.

(7). Documentation of all incidents of seclusion, restraint, or restrictive intervention.

(8). Relevant records from other agencies and systems including but not limited to:

- Initial Screens for Level of Care and Re-screens for continued stay
- Local Education Agency – Individual education plans
- Pertinent clinical documentation of services provided outside the facility

(9). Pertinent past and present medical history including diagnosis and the approximate date of diagnosis.

(b) The following criteria apply when developing the clinical record:

(1). The resident record shall be legible and stand on its own.

(2). The date and reason for every service must be included.

(3). Documentation must support the level of care provided in the PRTF.

(4). Assessments documented merely using a rubber stamp are not accepted unless there is documentation to the side of the stamp, which reflects results of the exam for each of the systems identified on the rubber stamp.

(5). Check marks are not accepted.

(6). Records must be created at the time the service is provided.

(c) The following questions should be asked to ensure appropriate documentation exists to support the level of service billed:

(1). Is the reason for the treatment documented in the resident record?

(2). Are all services that were provided documented?

(3). Does the resident record clearly explain why support services, procedures, supplies and medications were or were not provided?

(4). Is the assessment of the resident's condition apparent in the record?

(5). Does documentation contain information on the resident's progress and results of treatment?

(6). Does the resident record include a plan for treatment?

(7). Does information in the resident record provide medical rationale for the services?

(8). Does information in the resident record appropriately reflect the care provided in the case where another health care professional must assume care or perform necessary medical services on behalf of the facility? Is there documentation of timely referrals?

(d) Recordkeeping responsibilities rest with the provider.

785-3 Medication Documentation:

(a) All medication, including nonprescription medication, shall be given only in accordance with label directions, unless ordered differently by a physician, or a physician's assistant operating under written protocol as authorized by a physician, or an advanced registered nurse practitioner as authorized by a responsible physician and operating within their scope of practice. A record shall be kept in the resident's record documenting the following:

(1). The name of the person who gave the medication;

(2). The name of the medication;

(3). The dosage;

(4). The date and time it was given
(5). Any change in the residents' behavior, response to the medication, or adverse reactions
(6). Any change in the administration of the medication from the instructions on the label for a notation about each missed dose.

(b) Each record must be signed by the individual who was responsible for administering the medication.

785-4 Claim/Record Storage Requirements
(a) K.S.A. 21-3849 – Upon submitting a claim for or upon receiving payment for goods, services, items, facilities or accommodations under the Medicaid program, a person shall not destroy or conceal any records for five years after the date on which payment was received, if payment was received, or for five years after the date on which the claim was submitted, if the payment was not received.

(b) Providers who submit claims via computerized systems (i.e., tape) must maintain these records in a manner which is retrievable. If these storage requirements are in question, please review Section 1902 (a) (27), (A) and (B) of the Federal Social Security Act which requires providers (a) to keep such records as necessary to disclose fully the extent of services rendered to beneficiaries, and; (b) to furnish upon request by the state agency or secretary of Health and Human Services information on payment claimed by the provider.

(c) Providing medical records to the Kansas Medical Assistance Program or its designee is not a billable charge.

(d) Clinical records must be retained according to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) requirements.

785-5 Responsibilities of the physician and/or their designee:
(a). Regular and ongoing contact with all residents and more frequent contact for those residents on medication.
(b). Regular and ongoing contact with treatment staff to formulate and monitor the implementation of the resident's individual plan of care.
(c). Face-to-face or phone contact with the resident's family as needed.
(d). Contact as appropriate with external, community agencies, and natural supports important to the resident's life.
(e). Perform and prepare formal, written psychiatric evaluations as needed.
(f). Coordinate and/or advise facility staff on medical matters including the prescription and monitoring of psychotropic and other medication.
(g). Order the use of seclusion or restraint per CMS regulations.

(h) Telemedicine is allowed as long as residents are seen face-to-face by licensed, board eligible, or board certified physicians or their designees who are operating within their scope of practice under protocol for their initial medical evaluation.

785-6 Delegation of Nursing Tasks or Procedures:
Each registered professional nurse who delegates nursing tasks or procedures to a designated unlicensed person in the PRTF shall comply with the following requirements:
(a) Each registered professional nurse shall perform the following:
(1) Assess each resident's nursing care needs;
(2) Formulate a plan of care before delegating any nursing task or procedure to an unlicensed person; and
(3) Formulate a plan of nursing care for each resident who has one or more long-term or chronic health conditions requiring nursing interventions.

(b) The selected nursing task or procedure to be delegated shall be one that a reasonable and prudent nurse would determine to be within the scope of sound nursing judgment and that can be performed properly and safely by an unlicensed person.

(c) Any designated unlicensed person may perform basic caretaking tasks or procedures such as bathing, dressing, grooming, routine dental, hair and skin care, preparation of food for oral feeding, exercise (excluding occupational therapy and physical therapy procedures), toileting (including diapering and toilet training), and hand washing without delegation. After assessment and providing the needed training to a designated unlicensed person, a nurse may delegate specialized caretaking tasks such as catherization, ostomy care, preparation and administration of gastrostomy tube feedings, care of skin with damaged integrity or potential for this damage, administration of medications, and performance of other nursing procedures as selected by the registered professional nurse.

(d) The selected nursing task or procedure shall be one that does not require the designated unlicensed person to exercise nursing judgment or intervention.

(e) When an anticipated health crisis that is identified in a nursing care plan occurs, the unlicensed person may provide immediate care for which instruction has been provided.

(f) The designated unlicensed person to whom the nursing task or procedure is delegated shall be adequately identified by name in writing for each delegated task or procedure.

(g) The registered professional nurse shall orient and instruct unlicensed persons in the performance of the nursing task or procedure. The registered professional nurse shall document in writing the unlicensed person's demonstration of the competency necessary to perform the delegated task or procedure. The designated unlicensed person shall co-sign the documentation indicating the person's concurrence with this competency evaluation.

(h) The registered professional nurse shall meet these requirements:

(1) Be accountable and responsible for the delegated nursing task or procedure;
(2) participate in joint evaluations of the services rendered as needed;
(3) Record services performed; and
(4) Adequately supervise the performance of the delegated nursing task or procedure by assessing the appropriate factors before deciding to delegate which include the following: The health status and mental and physical stability of the resident receiving the nursing care, the complexity of the task or procedure to be delegated, the training and competency of the unlicensed person to whom the task or procedure is to be delegated, and the proximity and availability of the registered professional nurse to the designated unlicensed person when the selected nursing task or procedure will be performed. The supervising registered professional nurse may designate whether or not the nursing task or procedure is one that may be delegated or supervised by a licensed practical nurse. Each delegating registered professional nurse shall have a plan to provide nursing care when the delegating nurse is absent.

785-7 Supervision of delegated tasks or procedures:
Each registered professional or licensed practical nurse shall supervise all nursing tasks or procedures delegated to a designated unlicensed person in the PRTF setting in accordance with the following conditions.
(a) The registered professional nurse shall determine the degree of supervision required after an assessment of appropriate factors, including the following:

(1) The health status and mental and physical stability of the resident receiving the nursing care;
(2) The complexity of the task or procedure to be delegated;

(3) The training and competency of the unlicensed person to whom the task or procedure is to be delegated; and
(4) The proximity and availability of the registered professional nurse to the designated unlicensed person when the selected nursing task or procedure will be performed.

(b) The supervising registered professional nurse may designate whether or not the nursing task or procedure is one that may be delegated or supervised by a licensed practical nurse.

(c) Each delegating registered professional nurse shall have a plan to provide nursing care when the delegating nurse is absent.

785-8 Medication:
(a) A physician, physician's assistant, or an advanced registered nurse practitioner pursuant to a written protocol as authorized by a responsible physician may prescribe medication. Each protocol shall contain a precise and detailed medical plan of care for each classification of disease or injury for which the PA or ARNP is authorized to prescribe. The rationale for each medication and any changes in medication must be clearly documented in the resident's medical record. A physician, physician's assistant (PA), or advanced registered nurse practitioner (ARNP) permitted by the state must see each resident on psychotropic medications at least every thirty days, with progress and clinical status documented in writing. The clinical rationale for each medication must be clearly documented on the resident's discharge summary or final evaluation. When medication is deemed necessary, families and custodial case manger should be informed of the most effective treatment options available as well as possible side effects and the positive and negative outcomes associated with each medication.

785-9 Medication Storage
(a) The medicine cabinet shall be located in an accessible, supervised area. The cabinet shall be kept locked. Medication taken internally shall be kept separate from other medications. All unused medication shall be safely discarded.

785-10 Medication Administration:
(a) All medications shall be administered by a designated staff member qualified to administer medications. Prescription medication shall be given from a pharmacy container labeled with the following:

(1). The resident's name;
(2). The name of the medication;
(3). The dosage and the dosage intervals;
(4). The name of the prescribing physician; and
(5). The date the prescription was filled.

(b) Any changes of prescription or directions for administering a prescription medication shall be authorized, in writing, by a physician with documentation placed in the resident's record.

(c) Each PRTF shall ensure that all medications are prescribed by one of the following medical practitioners:

(1) A physician;

(2) A physician's assistant operating under a written protocol as authorized by a responsible physician; or

(3) An advanced registered nurse practitioner operating under a written protocol as authorized by a responsible physician and operating within their scope of practice.

(d) Each PRTF shall develop and implement policies, procedures, and clinical protocols for the administration of prescription and nonprescription medication. If medication is administered to a resident, each PRTF shall designate staff members to administer the medication. Before administering medication, each designated staff member must be delegated the authority to do so by a registered nurse as allowed under the Nurse Practice Act.

785-11 Staffing Requirements:

(a) The PRFT must be staffed appropriately to meet the needs of all the resident's in their care. The facility must also ensure there are an adequate number of multidisciplinary staffs to carry out the goals and objectives of the facility, and to ensure the delivery of individualized treatment to each resident as detailed in their program description.

(b) Minimum Staffing Level

Each PRTF shall meet the following minimum staff requirements:

(1) The governing body of each PRTF shall designate a head of the facility or administrator who is responsible for the day-to-day operations of the facility.

(2) A written daily staff schedule shall be developed and followed. The staff schedule shall meet all of the following requirements:

(i) The schedule shall provide for adequate staff to directly supervise and interact with the residents at all times, to implement each resident's individual plan for care, and to provide for each resident's physical, social, emotional, and educational needs.

(ii) The schedule shall provide for a minimum ratio of one direct care staff member on active duty to seven residents during waking hours and one direct care staff member on active duty to ten residents during sleeping hours.

(iii) At least one direct care staff member of the same sex as the resident shall be present, awake, and available to the resident at all times. If both male and female residents are present in the PRTF, at least one male and one female direct care staff member shall be present, awake, and available.

(3) Additional staff shall be available in the facility on all shifts to supplement the staff-to-resident ratio, to provide immediate assistance in case of an emergency and to periodically check on the status of the residents.

(4) Resident's shall remain in sight or sound observation range of staff at all times. The minimum ratio of direct care staff shall be immediately available in a connecting area to the sleeping rooms.

(5) Alternate qualified direct care staff members shall be provided for the relief of the regular staff members on a one-to-one basis and in compliance with the staffing pattern as required in number 2 above.

(6) Electronic supervision shall not replace the direct care staffing requirements.

(7) Auxiliary staff members shall be available as needed. The auxiliary staff shall include food service, clerical, and maintenance personnel. Auxiliary staff members shall not be included in meeting the minimum ratio of direct care staff to resident's served unless they have been properly trained as direct care staff.

(8) Professional consultant services shall be available, to the extent necessary, to meet the needs of the resident's served. Professional consultants shall include physicians, dentists, nurses, clergy, social workers, psychologists, psychiatrists, teachers, and dieticians.

(9) A volunteer shall not be used as a substitute for a direct care staff member, but shall augment the services provided by the staff.

(10) A staff person designated to be in charge of the PRTF shall be on-site at all times when a resident is in care. Procedures shall be in place to ensure that all staff members know who is in charge.

(c) Licensed Mental Health Professionals shall be available to ensure that the program can meet the stated active treatment as described in the PRTF's service description. At least one licensed mental health professional must be on-call during all hours the residents are sleeping to assist in emergencies.

785-12 Education:
(a) PRTF must ensure residents receive a free and appropriate education accredited by the Kansas State Board of Education.

785-13 Discipline:
(a) Discipline that is humiliating, frightening, or physically harmful to the resident shall not be used at any time. Each resident shall be protected against all forms of neglect, exploitation, or degrading forms of discipline. No resident shall be isolated or confined in any dark space. Electronic monitoring or an audio communication system shall not replace the required presence of a direct care staff.
(b) Corporal punishment shall not be used.
(c) Under no circumstances shall any youth be deprived of meals, clothing, sleep, medical services, exercise, correspondence, parental contact, or legal assistance for disciplinary purposes.
(d) Under no circumstance shall any youth be allowed to supervise or to administer discipline to another youth.
(e). The use of tazers, pepper spray, OC spray or any other similar devises used as an intervention or restraint is prohibited.

785-14 Family Participation:
(a) The PRTF shall ensure that the resident's family is given the opportunity to participate as full partners in the planning for delivery of services to the resident. Mutual respect between the facility staff and the family and inclusion of the family in all planning and decision-making are critical to successful treatment.
(b) The facility shall document all efforts to involve the resident's family in service planning and delivery.
(c) The facility shall ensure that the family is allowed to visit the resident frequently in the facility.
(d) The facility shall also ensure that the resident's identified family is able to communicate with the resident by telephone. In the rare circumstances that such communication or visits are not deemed therapeutic, the facility must document the clinical reasons for denying visits or phone calls and shall address these clinical issues in treatment planning and services. The facility must have at least one designated area on-campus for family visitation.

785-15 Confidentiality:
(a) Facilities must comply with all applicable state and federal confidentiality laws.

785-16 Absenteeism Policy:
(a) A resident shall be considered present at the facility for an entire day if the resident is at the facility at 11:59 pm. The facility should take a resident specific census at this time and ensure the facilities business manager has a record of which residents are present in the facility on any given day and can accurately track absentee

days for each resident. PRTF's will be reimbursed for absent days as follows:

(b) **Visitation Days:** When indicated in the child's plan of care (within the total number of days approved for the child's stay), a maximum of 7 days per visit will be paid at the contracted per diem rate. The frequency, duration, and location of the visits must be a part of the child's individual case plan developed by the facility prior to the visitation. An approved visitation plan must be documented in the child's official record at the facility.

(c) If a resident is absent from the facility for a short time due to circumstances needing the residents' immediate attention (deaths, weddings, personal business), or the resident leaves the facility without permission. The facility can be reimbursed for up to five days per year at the contracted per diem rate unless the resident's placement is terminated sooner by the resident's guardian in conjunction with the PRTF.

Emergency Exception Screen:
A resident can be admitted to a PRTF upon acceptance by the facility using the Emergency Exception Screen. The admission screen must be completed by the LMHP certifying need, within 48 hours of admission. The LMHP will certify that this is an exception screen and that the CBST plan has not yet been completed. The CBST will convene within 7 days of admission and determine if the resident needs can be met by the PRTF or should they be diverted to community-based services. If the certification determines that the resident needs can best be served in the community, then the resident must be moved from the PRTF. The placing agency will be responsible for payment after such determination.

Appeal Procedures:
Certification/Recertification Appeal Procedure:

If the facility physician disagrees with the screening determination and believes the resident needs to be certified or recertified to receive PRTF services, the facility physician may request an appeal review in writing to Kansas Health Solutions (KHS) . To request an appeal review of an initial certification, contact KHS at **1-866-547-0222** within fifteen (15) working days from the date of the screening. A psychiatrist will conduct an appeal review within two working days of the request pending receipt of appropriate documentation. To request an appeal review of a recertification, contact KHS at **1-866-547-0222** within five (5) working days from the date of rescreening. A psychiatrist will conduct an appeal review within two working days of the request pending receipt of appropriate documentation.

Screening decisions will be provided to the beneficiary or legal guardian in writing, and will include a notice concerning the right to a fair hearing. Beneficiary or legal guardian has the right to a fair hearing process, and must make a written request, received within 30 days from the date of the notice of action. An additional (3) days shall be allowed if the notice is mailed.
KHS shall assume responsibility for presenting their case in the fair hearing process and will provide to the beneficiary and the legal guardian copies of the pre-admission screening case records to be utilized in the fair hearing process. SRS reserves the right to conduct an administrative review of all fair hearings.

Unconditional Release from a Psychiatric Residential Treatment Facility
An individual who is under age 22 and has been receiving inpatient psychiatric services in a Psychiatric Residential Treatment Facility (PRTF) is considered to be a resident in the institution until he/she is unconditionally released or, if earlier, the date he/she reaches age 22.

An unconditional release will only occur under the following conditions:

1. PRTF Goals met/achieved, youth discharged successfully from PRTF.
2. PRTF Goals not met/achieved, youth transferred to other IMD (other PRTF or State Psychiatric Hospital)
3. PRTF Goals not met/achieved, family/youth or guardian choice to discontinue services.

4. Youth placed in a correctional facility or removed from treatment and placed for longer than 72 hours while awaiting a court hearing.
5. Youth runs away from the facility and is gone for 7 consecutive calendar days with the facility having no knowledge of when the youth may return.
6. The youth is receiving inpatient medical treatment in a hospital.
7. The youth has died.

Measurable outcomes:
All Psychiatric Residential Treatment Facility providers must meet the outcome standards, and be incompliance with data collection, and reporting; as stated by Social and Rehabilitative Services of Kansas, Disability and Behavioral Health Services, Mental Health.

Changing of Standards:
The services described in the manual are funded by federal and state dollars. Rules and regulations governing the programs are subject to change. From time to time, it will be necessary for the state to revise rules, regulations, and eligibility requirements in accordance with statutory provisions when such changes are necessitated by budgetary limitations or other circumstances. When changing of standards, SRS will elicit feedback from identified internal and external stakeholders.

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ATTACHMENT A
Kansas State Medicaid Plan Definition
Of a Psychiatric Residential Treatment Facility (PRTF)

These programs are intended to provide active treatment in a structured therapeutic environment for youth with significant functional impairments resulting from an identified mental health diagnosis, substance abuse diagnosis, and/or a mental health diagnosis with a co-occurring disorder (i.e. substance related disorders, mental retardation/developmental disabilities, head injury, sexual misuse disorders, or other disabilities which may require stabilization of mental health issues). Such services are provided in consideration of a child's developmental stage.

Services must be provided in accordance with an individualized plan of care under the direction of a physician. The activities included in the service must be intended to achieve identified plan of care goals and objectives and be designed to achieve the recipient's discharge from inpatient status at the earliest possible time. Services to be provided must be in accordance with 42 CFR 441.154 - 441.156.

Recipients of these services must be assessed by a Licensed Mental Health Practitioner (LMHP) or physician who is independent of the treating facility, utilizing an assessment consistent with state law, regulation and policy. Utilizing this assessment a Community Based Services Team (CBST) which complies with the requirement of 42 CFR 441.153 must certify in writing the medical necessity of this level of care in accordance with the criteria and requirements outlined in 42 CFR 441.152. In addition, the need for this level of care will be evidenced by:

- a substantial risk of harm to self or others, or a child who is so unable to care for his or her own physical health and safety as to create a danger to their life; and
- the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed; and
- all other ambulatory care resources available in the community have been identified and if not accessed determined to not meet the immediate treatment needs of the youth.

After admission, a Licensed Mental Health Practitioner (LMHP) or physician who is independent of the treating facility must re-certify in writing the need for this continued level of care on a regularly scheduled basis as defined by state law, regulation, and/or policy.

Services furnished in a psychiatric residential treatment facility must satisfy all requirements in subpart G of 42 CFR 483 governing the use of restraint and seclusion.

Provider Qualifications:
Providers of Inpatient Psychiatric Services for Individuals under the age of 21 must meet all general requirements for participation as specified in 42 CFR 441.151.

Additionally, a psychiatric residential treatment facility must meet the requirements and standards of state certification and licensure, and national accreditation by The Joint Commission, the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, or by any other accrediting organization, with comparable standards, which is recognized by the State.

Services must be under the direction of a physician and all staff must meet applicable licensure and certification requirements and adhere to scope of practice definitions of state licensure boards.

Limitations:
An individual under age 22 who has been receiving this service is considered a resident of the PRTF until he is unconditionally released or, if earlier, the date he reaches age 22.

Reserve days, for periods of absence from a PRTF, will be reimbursed to providers with prior approval.

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ATTACHMENT B

Psychiatric Residential Treatment:
Complaint/Concern Process

Whenever a resident/family, legal guardian or other involved party has concerns or disagreements about psychiatric residential treatment or related issues follow these steps in sequence:

1. **Initiate open discussion with the concerned parties closest to the problem, attempting to find resolution. This includes taking the concerns to a supervisory level if needed to attempt resolution.**

If the concerns are not resolved satisfactorily or if it is the resident's / family's preference at any point in the process:

2. **Contact the assigned SRS – Mental Health Field Representative. A listing of contact information for the MH Field Staff can be found at:**
   http://www.srskansas.org/hcp/MHSIP/QEStaffListing.htm

RIGHT TO REQUEST A FAIR HEARING:

You have the right to ask for a fair hearing if you do not agree with the State Department of Social and Rehabilitation Services (SRS) or the State Department of Administration (KDA) decision made regarding your case. At the hearing, you can explain why you do not agree. A household member, lawyer, friend, relative, advocate, or any other person you want may speak for you at the hearing. For medical assistance, you have the right to a hearing if your request has been received before the date the decision becomes effective. Your medical assistance may continue at the current level while a hearing is being made. Any benefits you receive while waiting on the decision may be recovered if the decision is not in your favor. If you are dissatisfied with a fair hearing decision, you may request further review of the decision.

To request a fair hearing, you must file a written request with the Office of Administrative Hearings, 1020 S. Kansas Avenue, Topeka, KS 66612 within 30 days of the written notice. If the notice of denial was mailed to you, K.S.A. 77-531 allows you an additional three days to file a Fair Hearing request.

CIVIL RIGHTS PROVISION:

No person shall, on basis of age, race, color, sex, handicap, religious creed, national origin, or political belief, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity of the State Department of Social and Rehabilitation Services or the State Department of Administration. If you feel that you have been discriminated against you may file a complaint in writing to SRS or KDA, to the State of Kansas Human Right Commission Landon State Office Bldg., 900 SW Jackson Street, Suite 568 South Topeka, Kansas 66612-1258, or to the United States Commission on Civil Rights, Central Regional Office**,** Suite 908, 400 State Avenue, Kansas City, Kansas 66101